Louis LaTorre, Sr. Director
Social Services/dra

BOARD OF COUNTY COMMISSIONERS
AGENDA ITEM SUMMARY

Meeting Date: March 16, 2005

Division: Community Services

Bulk Item: Yes X No ___

Department: Social Services

Staff Contact Person: Deloris Simpson

AGENDA ITEM WORDING: Approval of Amendment #001 to Contract #KG051-Community Care for Disabled Adults (CCDA) between the State of Florida, Department of Children & Families and the Monroe County Board of County Commissioners (Monroe County Social Services/In-Home Services Program) for Fiscal year July 1, 2004 through June 30, 2005.

ITEM BACKGROUND: Approval of Amendment #001 will reduce funding to $81,733.00 at a reduction of $1,866.00.

PREVIOUS RELEVANT BOCC ACTION: June 6, 2004

CONTRACT/AGREEMENT CHANGES: Reduction of funds from $83,599.00 to $81,733.00

STAFF RECOMMENDATIONS: Approval

TOTAL COST: $81,733.00 **BUDGETED:** Yes X No

COST TO COUNTY: (Required Match)$9,085.89 **SOURCE OF FUNDS:** CCDA Contract for Fiscal year 7/2004 thru 6/2005

REVENUE PRODUCING: Yes ___ No X **AMOUNT PER MONTH**____ **Year** ____

APPROVED BY: County Atty X OMB/Purchasing X Risk Management X

DIVISION DIRECTOR APPROVAL: _____
JIM MALLOCH, Division Director

DOCUMENTATION: Included X Not Required ____

DISPOSITION:_____ **AGENDA ITEM #**_____

Revised 2/05

MONROE COUNTY BOARD OF COUNTY COMMISSIONERS

CONTRACT SUMMARY

Contract with: State of Florida/Department of Children & Families

Contract: Amendment #1 to Contract #KG051
Effective Date: March 16, 2005
Expiration Date: June 30, 2005

Contract Purpose/Description: Approval of Amendment #001 to Contract #KG051 - Community Care for Disabled Adults (CCDA) to reduce funding from $83,599.00 o $/81,733.00 at a reduction of $1,866.00

Contract Manager:	Deloris Simpson (Name)	4589 (Ext.)	Social Services/Stop 1 (Department/Stop #)

For BOCC meeting on 3/16/2005 Agenda Deadline: 3/1/2005

CONTRACT COSTS

Total Dollar Value of Contract: $81,733.00
Budgeted? Yes X No
Grant: $ 81,733.00 (Fiscal Year)
County Match: $ 9,085.89 (Fiscal Year)

Account Codes: _____-_____-_____-_____-_____

Current Year Portion: $_____

_____-_____-_____-_____-_____
_____-_____-_____-_____-_____
_____-_____-_____-_____-_____

ADDITIONAL COSTS

Estimated Ongoing Costs: $_____/yr
(Not included in dollar value above)

For: _____
(eg. Maintenance, utilities, janitorial, salaries, etc)

CONTRACT REVIEW

	Date In	Changes Needed		Reviewer	Date Out
Division Director	2/9/05	Yes	No		2/9/05
Risk Management	2-8-05	Yes	No	M. Sleeuwenhoek	2805
O.M.B./Purchasing	02/09/05	Yes	No		2/9/05
County Attorney	2/8/05	Yes	No		2/08/05

Comments: needs copy of original contract attached.

OMB Form Revised 2/27/01 MCP #2

CONTRACT #KG051

AMENDMENT #0001

THIS AMENDMENT, entered into between the Florida Department of Children and Families, hereinafter referred to as the "department" , and Monroe County (Monroe County In Home Services), hereinafter referred to as the "provider", amends contract KG051.

1. Standard Contract, Section II, Paragraph A is hereby amended to read:

To pay for contracted services according to the terms and conditions of this contract in an amount not to exceed $81,773.00, subject to the availability of funds. The State of Florida's performance and obligation to pay under this contract is contingent upon an annual appropriation by the Legislature. Any costs or services paid for under any other contract for from any other source are not eligible for payment under this contract.

2. Attachment I, Section C, Paragraphs 1.a., 1.b and 1.c. are hereby amended to read:

1. Payment Clause

a. This is a Fixed Price contract. The department shall pay the provider for the delivery of service units provided in accordance with the terms and conditions of this contract for a total dollar amount not to exceed $81,733.00, subject to the availability of funds.

b. The department shall make payments to the provider for provision of services up to the maximum number of units of service at the rates shown below.

Service Units	Unit Price	Maximum # of Units
Case Management	$ 47.73	228
Homemaking	$ 27.11	1517
Home Delivered Meals	$ 5.10	4000
Personal Care	$ 51.11	183

c. The provider's dollar match for this contract is $9,085.89. Case management and transportation services may be exempt from match requirement at the discretion of each district.

4. This amendment shall begin on March 1, 2005, or the date on which the amendment has been signed by both parties, whichever is later.

5. All provisions in the contract and any attachments thereto in conflict with this amendment shall be and are hereby changed to conform with the amendment.

AMENDMENT# 0001
KG051

6. All provisions not in conflict with this amendment are still in effect and are to be performed at the level specified in the contract.

7. This amendment and all its attachments are hereby made a part of this contract.

IN WITNESS WHEREOF, the parties hereto have caused this 2 page amendment to be executed by their officials thereunto duly authorized.

PROVIDER: MONROE COUNTY
(Monroe County In Home Services)

SIGNED
BY:_____

NAME: Dixie M. Spehar

TITLE: Mayor

DATE_____

FEDERAL ID NUMBER: 590600074902

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES

SIGNED
BY:_____

NAME: Charles M. Hood III

TITLE: District Administrator

DATE_____

APPROVED AS TO FORM
AND LEGAL SUFFICIENCY
12/05
Assistant District Counsel

MONROE COUNTY ATTORNEY
APPROVED AS TO FORM:
SUZANNE A. HUTTON
ASSISTANT COUNTY ATTORNEY
Date 2/06/05

03/23/04

CFDA No. _____

Client ☑ Non-Client ☐
Multi-District ☐

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
STANDARD CONTRACT

THIS CONTRACT is entered into between the Florida Department of Children and Families, hereinafter referred to as the "department," and Monroe County (Monroe County In Home Services)

_____ hereinafter referred to as the "provider."

I. THE PROVIDER AGREES:

A. Contract Document
To provide services in accordance with the terms and conditions specified in this contract including all attachments and exhibits, which constitute the contract document.

B. Requirements of Section 287.058 F.S.
To provide units of deliverables, including reports, findings, and drafts, as specified in this contract, which must be received and accepted by the contract manager in writing prior to payment. To submit bills for fees or other compensation for services or expenses in sufficient detail for a proper pre-audit and post-audit. Where itemized payment for travel expenses are permitted in this contract, to submit bills for any travel expenses in accordance with section 112.061, F.S. or at such lower rates as may be provided in this contract. To allow public access to all documents, papers, letters, or other public records as defined in subsection 119.011(1), F.S., made or received by the provider in conjunction with this contract except that public records which are made confidential by law must be protected from disclosure. It is expressly understood that the provider's failure to comply with this provision shall constitute an immediate breach of contract for which the department may unilaterally terminate the contract.

C. Governing Law
1. State of Florida Law
That this contract is executed and entered into in the State of Florida, and shall be construed, performed and enforced in all respects in accordance with the Florida law including Florida provisions for conflict of laws.

2. Federal Law

a. That if this contract contains federal funds the provider shall comply with the provisions of 45 CFR, Part 74, and/or 45 CFR, Part 92, and other applicable regulations.

b. That if this contract contains federal funds and is over $100,000, the provider shall comply with all applicable standards, orders, or regulations issued under section 306 of the Clean Air Act, as amended (42 U.S.C. 7401 et seq.), section 508 of the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 et seq.), Executive Order 11738 as amended and where applicable, and Environmental Protection Agency regulations (40 CFR, Part 30). The provider shall report any violations of the above to the department.

c. That no federal funds received in connection with this contract may be used by the provider, or agent acting for the provider, to influence legislation or appropriations pending before the Congress or any State legislature. If this contract contains federal funding in excess of $100,000, the provider must, prior to contract execution, complete the Certification Regarding Lobbying form, Attachment N/A. If a Disclosure of Lobbying Activities form, Standard Form LLL, is required, it may be obtained from the contract manager. All disclosure forms as required by the Certification Regarding Lobbying form must be completed and returned to the contract manager, prior to payment under this contract.

d. That unauthorized aliens shall not be employed. The department shall consider the employment of unauthorized aliens a violation of section 274A(e) of the Immigration and Nationality Act (8 U.S.C. 1324 a). Such violation shall be cause for unilateral cancellation of this contract by the department.

e. That if this contract contains $10,000 or more of federal funds, the provider shall comply with Executive Order 11246, Equal Employment Opportunity, as amended by Executive Order 11375 and others, and as supplemented in Department of Labor regulation 41 CFR, Part 60 and 45 CFR, Part 92, if applicable.

f. That if this contract contains federal funds and provides services to children up to age 18, the provider shall comply with the Pro-Children Act of 1994 (20 U.S.C. 6081). Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. This clause is applicable to all subcontracts.

D. Audits, Inspections, Investigations, Records and Retention
1. To establish and maintain books, records and documents (including electronic storage media) sufficient to reflect all income and expenditures of funds provided by the department under this contract.

2. To retain all client records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to this contract for a period of six (6) years after completion of the contract. If an audit has been initiated and audit findings have not been resolved at the end of six (6) years, the records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of this contract, at no

additional cost to the department. Records shall be retained for longer periods when the retention period exceeds the time frames required by law.

3. Upon demand, at no additional cost to the department, the provider will facilitate the duplication and transfer of any records or documents during the required retention period in Subsection I, Paragraph D.2.

4. To assure that these records shall be subject at all reasonable times to inspection, review, copying, or audit by Federal, State, or other personnel duly authorized by the department.

5. At all reasonable times for as long as records are maintained, persons duly authorized by the department and Federal auditors, pursuant to 45 CFR, Section 92.36(i) (10), shall be allowed full access to and the right to examine any of the provider's contracts and related records and documents, regardless of the form in which kept.

6. To provide a financial and compliance audit to the department as specified in this contract and in Attachment II and to ensure that all related party transactions are disclosed to the auditor.

7. To comply and cooperate immediately with any inspections, reviews, investigations, or audits deemed necessary by the office of The Inspector General (Section 20.055, Florida Statutes).

8. To include the aforementioned audit, inspections, investigations and record keeping requirements in all subcontracts and assignments.

E. Monitoring by the Department

To permit persons duly authorized by the department to inspect and copy any records, papers, documents, facilities, goods and services of the provider which are relevant to this contract, and to interview any clients, employees and subcontractor employees of the provider to assure the department of the satisfactory performance of the terms and conditions of this contract. Following such review, the department will deliver to the provider a written report of its findings and request for development, by the provider of a corrective action plan where appropriate. The provider hereby agrees to timely correct all deficiencies identified in the corrective action plan.

F. Indemnification

NOTE: Except to the extent permitted by s.768.28 , F.S., or other applicable Florida Law, paragraphs I.F.1. and 2. are not applicable to contracts executed between state agencies or subdivisions, as defined in subsection 768.28(2), F.S.

1. To be liable for and indemnify, defend, and hold the department and all of its officers, agents, and employees harmless from all claims, suits, judgments, or damages, including attorneys' fees and costs, arising out of any act, actions, neglect, or omissions by the provider, its agents, or employees during the performance or operation of this contract or any subsequent modifications thereof.

2. That its inability to evaluate its liability or its evaluation of liability shall not excuse the provider's duty to defend and to indemnify within seven (7) days after notice by the department by certified mail. After the highest appeal taken is exhausted, only an adjudication or judgment specifically finding the provider not liable shall excuse performance of this provision. The provider shall pay all costs and fees including attorneys' fees related to these obligations and their enforcement by the department. The department's failure to notify the provider of a claim shall not release the provider from these duties. The provider shall not be liable for the sole negligent acts of the department.

G. Insurance

To provide continuous adequate liability insurance coverage during the existence of this contract and any renewal(s) and extension(s) of it. By execution of this contract, unless it is a state agency or subdivision as defined by subsection 768.28(2), F.S., the provider accepts full responsibility for identifying and determining the type(s) and extent of liability insurance necessary to provide reasonable financial protections for the provider and the clients to be served under this contract. Upon the execution of this contract, the provider shall furnish the department written verification supporting both the determination and existence of such insurance coverage. Such coverage may be provided by a self-insurance program established and operating under the laws of the State of Florida. The department reserves the right to require additional insurance as specified in this contract.

H. Confidentiality of Client Information

Not to use or disclose any information concerning a recipient of services under this contract for any purpose prohibited by state or federal law or regulations (except with the written consent of a person legally authorized to give that consent or when authorized by law).

I. Assignments and Subcontracts

1. To neither assign the responsibility for this contract to another party nor subcontract for any of the work contemplated under this contract without prior written approval of the department which shall not be unreasonably withheld. Any sublicense, assignment, or transfer otherwise occurring without prior approval of the department shall be null and void.

2. To be responsible for all work performed and for all commodities produced pursuant to this contract whether actually furnished by the provider or its subcontractors. Any subcontracts shall be evidenced by a written document. The provider further agrees that the department shall not be liable to the subcontractor in any way or for any reason. The provider, at its expense, will defend the department against such claims.

3. To make payments to any subcontractor within seven (7) working days after receipt of full or partial payments from the department in accordance with section 287.0585, F.S., unless otherwise stated in the contract between the provider

and subcontractor. Failure to pay within seven (7) working days will result in a penalty that shall be charged against the provider and paid to the subcontractor in the amount of one-half of one percent (.005) of the amount due per day from the expiration of the period allowed for payment. Such penalty shall be in addition to actual payments owed and shall not exceed fifteen (15%) percent of the outstanding balance due.

4. That the State of Florida shall at all times be entitled to assign or transfer its rights, duties, or obligations under this contract to another governmental agency in the State of Florida, upon giving prior written notice to the provider. In the event the State of Florida approves transfer of the provider's obligations, the provider remains responsible for all work performed and all expenses incurred in connection with the contract. This contract shall remain binding upon the successors in interest of either the provider or the department.

J. Return of Funds

To return to the department any overpayments due to unearned funds or funds disallowed pursuant to the terms and conditions of this contract that were disbursed to the provider by the department. In the event that the provider or its independent auditor discovers that an overpayment has been made, the provider shall repay said overpayment immediately without prior notification from the department. In the event that the department first discovers an overpayment has been made, the contract manager, on behalf of the department, will notify the provider by letter of such findings. Should repayment not be made forthwith, the provider will be charged at the lawful rate of interest on the outstanding balance after department notification or provider discovery.

K. Client Risk Prevention and Incident Reporting

1. That if services to clients are to be provided under this contract, the provider and any subcontractors shall, in accordance with the client risk prevention system, report those reportable situations listed in CFOP 215-6 in the manner prescribed in CFOP 215-6 or district operating procedures.

2. To immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-96ABUSE). As required by Chapters 39 and 415, F.S., this provision is binding upon both the provider and its employees.

L. Purchasing

1. To purchase articles which are the subject of or are required to carry out this contract from Prison Rehabilitative Industries and Diversified Enterprises, Inc., (PRIDE) identified under Chapter 946, F.S., in the same manner and under the procedures set forth in subsections 946.515(2) and (4), F.S. For purposes of this contract, the provider shall be deemed to be substituted for the department insofar as dealings with PRIDE. **This clause is not applicable to subcontractors unless otherwise required by law.** An abbreviated list of products/services available from PRIDE may be obtained by contacting PRIDE, (850) 487-3774.

2. To procure any recycled products or materials, which are the subject of or are required to carry out this contract, in accordance with the provisions of sections 403.7065, and 287.045, F.S.

M. Civil Rights Requirements

1. Not to discriminate against any employee in the performance of this contract or against any applicant for employment because of age, race, religion, color, disability, national origin, marital status or sex. The provider further assures that all contractors, subcontractors, subgrantees, or others with whom it arranges to provide services or benefits to participants or employees in connection with any of its programs and activities are not discriminating against those participants or employees because of age, race, religion, color, disability, national origin, marital status or sex. This is binding upon the provider employing fifteen (15) or more individuals.

2. To complete the Civil Rights Compliance Questionnaire, CF Forms 946 A and B, in accordance with CFOP 60-16. This is binding upon providers that have fifteen (15) or more employees.

N. Independent Capacity of the Contractor

1. To act in the capacity of an independent contractor and not as an officer, employee of the State of Florida, except where the provider is a state agency. Neither the provider nor its agents, employees, subcontractors or assignees shall represent to others that it has the authority to bind the department unless specifically authorized in writing to do so.

2. This contract does not create any right to state retirement, leave benefits or any other benefits of state employees as a result of performing the duties or obligations of this contract.

3. To take such actions as may be necessary to ensure that each subcontractor of the provider will be deemed to be an independent contractor and will not be considered or permitted to be an agent, servant, joint venturer, or partner of the State of Florida.

4. The department will not furnish services of support (e.g., office space, office supplies, telephone service, secretarial or clerical support) to the provider, or its subcontractor or assignee, unless specifically agreed to by the department in this contract.

5. All deductions for social security, withholding taxes, income taxes, contributions to unemployment compensation funds and all necessary insurance for the provider, the provider's officers, employees, agents, subcontractors, or assignees shall be the sole responsibility of the provider.

O. Sponsorship
As required by section 286.25, F.S., if the provider is a non-governmental organization which sponsors a program financed wholly or in part by state funds, including any funds obtained through this contract, it shall, in publicizing, advertising, or describing the sponsorship of the program, state: "Sponsored by (provider's name) and the State of Florida, Department of Children and Families." If the sponsorship reference is in written material, the words "State of Florida, Department of Children and Families" shall appear in the same size letters or type as the name of the organization.

P. Publicity
Without limitation, the provider and its employees, agents, and representatives will not, without prior departmental written consent in each instance, use in advertising, publicity or any other promotional endeavor any State mark, the name of the State's mark, the name of the State or any State affiliate or any officer or employee of the State, or represent, directly or indirectly, that any product or service provided by the provider has been approved or endorsed by the State, or refer to the existence of this contract in press releases, advertising or materials distributed to the provider's prospective customers.

Q. Final Invoice
To submit the final invoice for payment to the department no more than 45 days after the contract ends or is terminated. If the provider fails to do so, all rights to payment are forfeited and the department will not honor any requests submitted after the aforesaid time period. Any payment due under the terms of this contract may be withheld until all reports due from the provider and necessary adjustments thereto have been approved by the department.

R. Use of Funds for Lobbying Prohibited
To comply with the provisions of sections 11.062 and 216.347, F.S., which prohibit the expenditure of contract funds for the purpose of lobbying the Legislature, judicial branch, or a state agency.

S. Public Entity Crime
Pursuant to section 287.133, F.S., the following restrictions are placed on the ability of persons convicted of public entity crimes to transact business with the department: When a person or affiliate has been placed on the convicted vendor list following a conviction for a public entity crime, he/she may not submit a bid on a contract to provide any goods or services to a public entity, may not submit a bid on a contract with a public entity for the construction or the repair of a public building or public work, may not submit bids on leases of real property to a public entity, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in section 287.017, F.S., for CATEGORY TWO for a period of thirty-six (36) months from the date of being placed on the convicted vendor list.

T. Patents, Copyrights, and Royalties

1. If any discovery or invention arises or is developed in the course of or as a result of work or services performed under this contract, or in anyway connected herewith, the provider shall refer the discovery or invention to the department to be referred to the Department of State to determine whether patent protection will be sought in the name of the State of Florida. Any and all patent rights accruing under or in connection with the performance of this contract are hereby reserved to the State of Florida.

2. In the event that any books, manuals, films, or other copyrightable materials are produced, the provider shall notify the Department of State. Any and all copyrights accruing under or in connection with performance under this contract are hereby reserved to the State of Florida.

3. The provider, if not a state agency, shall indemnify and save the department and its employees harmless from any liability whatsoever, including costs and expenses, arising out of any copyrighted, patented, or unpatented invention, process, or article manufactured or used by the provider in the performance of this contract.

4. The department will provide prompt written notification of any claim of copyright or patent infringement. Further, if such claim is made or is pending, the provider may, at its option and expense, procure for the department, the right to continue use of, replace, or modify the article to render it non-infringing. If the provider uses any design, device, or materials covered by letters, patent, or copyright, it is mutually agreed and understood without exception that the compensation paid pursuant to this contract includes all royalties or costs arising from the use of such design, device, or materials in any way involved in the work contemplated by this contract.

U. Construction or Renovation of Facilities Using State Funds
That any state funds provided for the purchase of or improvements to real property are contingent upon the provider granting to the state a security interest in the property at least to the amount of the state funds provided for at least five (5) years from the date of purchase or the completion of the improvements or as further required by law. As a condition of receipt of state funding for this purpose, the provider agrees that, if it disposes of the property before the department's interest is vacated, the provider will refund the proportionate share of the state's initial investment, as adjusted by depreciation.

V. Information Security Obligations

1. To identify an appropriately skilled individual to function as its Data Security Officer who shall act as the liaison to the department's Security Staff and who will maintain an appropriate level of data security for the information the provider is collecting or using in the performance of this contract. An appropriate level of security includes approving and tracking all provider employees that request system or information access and ensuring that user access has been removed from all terminated provider employees.

2. To hold the department harmless from any loss or damage incurred by the department as a result of information technology used, provided or accessed by the provider.

3. To furnish Security Awareness Training to its staff.

4. To ensure that all provider employees who have access to departmental information are provided a copy of CFOP 50-6 and that they sign the DCF Security Agreement form (CF 114), a copy of which may be obtained from the contract manager.

W. Accreditation

That the department is committed to ensuring provision of the highest quality services to the persons we serve. Accordingly, the department has expectations that where accreditation is generally accepted nationwide as a clear indicator of quality service, the majority of our providers will either be accredited, have a plan to meet national accreditation standards, or will initiate one within a reasonable period of time.

X. Agency for Workforce Innovation and Workforce Florida

That it understands that the department, the Agency for Workforce Innovation, and Workforce Florida, Inc. have jointly implemented an initiative to empower recipients in the Temporary Assistance to Needy Families Program to enter and remain in gainful employment. The department encourages provider participation with the Agency for Workforce Innovation and Workforce Florida.

Y. Health Insurance Portability and Accountability Act

Where applicable, to comply with the Health Insurance Portability and Accountability Act (42 U. S. C. 1320d.) as well as all regulations promulgated thereunder (45 CFR Parts 160, 162, and 164).

Z. Emergency Preparedness

If the tasks to be performed pursuant to this contract include the physical care and control of clients, the provider shall, within 30 days of the execution of this contract, submit to the contract manager an emergency preparedness plan which shall include provisions for pre-disaster records protection, alternative accommodations for clients in substitute care, supplies, and a recovery plan that will allow the provider to continue functioning in compliance with the executed contract in the event of an actual emergency. The department agrees to respond in writing within 30 days of receipt of the plan accepting, rejecting, or requesting modifications. In the event of an emergency, the department may exercise oversight authority over such provider in order to assure implementation of agreed emergency relief provisions.

II. THE DEPARTMENT AGREES:

A. Contract Amount

To pay for contracted services according to the terms and conditions of this contract in an amount not to exceed $ 83,599.00 , subject to the availability of funds. The State of Florida's performance and obligation to pay under this contract is contingent upon an annual appropriation by the Legislature. Any costs or services paid for under any other contract or from any other source are not eligible for payment under this contract.

B. Contract Payment

Pursuant to section 215.422, F.S., the department has five (5) working days to inspect and approve goods and services, unless the bid specifications, purchase order, or this contract specify otherwise. With the exception of payments to health care providers for hospital, medical, or other health care services, if payment is not available within forty (40) days, measured from the latter of the date a properly completed invoice is received by the department or the goods or services are received, inspected, and approved, a separate interest penalty set by the Comptroller pursuant to section 55.03, F.S., will be due and payable in addition to the invoice amount. Payments to health care providers for hospital, medical, or other health care services, shall be made not more than thirty-five (35) days from the date eligibility for payment is determined. Financial penalties will be calculated at the daily interest rate of .03333%. Invoices returned to a provider due to preparation errors will result in a non-interest bearing payment delay. Interest penalties less than one (1) dollar will not be paid unless the provider requests payment.

C. Vendor Ombudsman

A Vendor Ombudsman has been established within the Department of Financial Services. The duties of this office are found in subsection 215.422 (7), F.S., which include disseminating information relative to the prompt payment of this state and assisting vendors in receiving their payments in a timely manner from a state agency. The Vendor Ombudsman may be contacted at (850) 410-9724 or 1-800-848-3792, the State of Florida Comptroller's Hotline.

D. Notice
Any notice, that is required under this contract shall be in writing, and sent by U.S. Postal Service or any expedited delivery service that provides verification of delivery or by hand delivery. Said notice shall be sent to the representative of the provider responsible for administration of the program, to the designated address contained in this contract.

III. THE PROVIDER AND DEPARTMENT MUTUALLY AGREE:

A. Effective and Ending Dates
This contract shall begin on July 1, 2004, or on the date on which the contract has been signed by the last party required to sign it, whichever is later. It shall end at midnight, local time in Monroe County, Florida, on June 30, 2005.

B. Financial Penalties for Failures to Comply with Requirement for Corrective Action.
1. In accordance with the provisions of Section 402.73(7), Florida Statutes, and Section 65-29.001, Florida Administrative Code, corrective action plans may be required for noncompliance, nonperformance, or unacceptable performance under this contract. Penalties may be imposed for failures to implement or to make acceptable progress on such corrective action plans.
2. The increments of penalty imposition that shall apply, unless the department determines that extenuating circumstances exist, shall be based upon the severity of the noncompliance, nonperformance, or unacceptable performance that generated the need for corrective action plan. The penalty, if imposed, shall not exceed ten percent (10%) of the total contract payments during the period in which the corrective action plan has not been implemented or in which acceptable progress toward implementation has not been made. Noncompliance that is determined to have a direct effect on client health and safety shall result in the imposition of a ten percent (10%) penalty of the total contract payments during the period in which the corrective action plan has not been implemented or in which acceptable progress toward implementation has not been made.
3. Noncompliance involving the provision of service not having a direct effect on client health and safety shall result in the imposition of a five percent (5%) penalty. Noncompliance as a result of unacceptable performance of administrative tasks shall result in the imposition of a two percent (2%) penalty.
4. The deadline for payment shall be as stated in the Order imposing the financial penalties. In the event of nonpayment the department may deduct the amount of the penalty from invoices submitted by the provider.

C. Termination
1. This contract may be terminated by either party without cause upon no less than thirty (30) calendar days notice in writing to the other party unless a sooner time is mutually agreed upon in writing. Said notice shall be delivered by U.S. Postal Service or any expedited delivery service that provides verification of delivery or by hand delivery to the contract manager or the representative of the provider responsible for administration of the program.
2. In the event funds for payment pursuant to this contract become unavailable, the department may terminate this contract upon no less than twenty-four (24) hours notice in writing to the provider. Said notice shall be sent by U.S. Postal Service or any expedited delivery service that provides verification of delivery. The department shall be the final authority as to the availability and adequacy of funds. In the event of termination of this contract, the provider will be compensated for any work satisfactorily completed.
3. This contract may be terminated for the provider's non-performance upon no less than twenty-four (24) hours notice in writing to the provider. If applicable, the department may employ the default provisions in Rule 60A-1.006(3), F.A.C. Waiver of breach of any provisions of this contract shall not be deemed to be a waiver of any other breach and shall not be construed to be a modification of the terms and conditions of this contract. The provisions herein do not limit the department's right to remedies at law or in equity.
4. Failure to have performed any contractual obligations with the department in a manner satisfactory to the department will be a sufficient cause for termination. To be terminated as a provider under this provision, the provider must have: (1) previously failed to satisfactorily perform in a contract with the department, been notified by the department of the unsatisfactory performance, and failed to correct the unsatisfactory performance to the satisfaction of the department; or (2) had a contract terminated by the department for cause.

D. Renegotiations or Modifications
Modifications of provisions of this contract shall be valid only when they have been reduced to writing and duly signed by both parties. The rate of payment and the total dollar amount may be adjusted retroactively to reflect price level increases and changes in the rate of payment when these have been established through the appropriations process and subsequently identified in the department's operating budget.

E. Official Payee and Representatives (Names, Addresses, and Telephone Numbers):

1. The provider name, as shown on page 1 of this contract, and mailing address of the official payee to whom the payment shall be made is:
Monroe County (Monroe County In Home Services
1100 Simonton Street
Key West, FL 33040

2. The name of the contact person and street address where financial and administrative records are maintained is:
Deloris Simpson
Monroe County In Home Services
1100 Simonton Street
Key West, FL 33040

3. The name, address, and telephone number of the contract manager for the department for this contract is:
Theresa Phelan
Department of Children and Families
1111 12th Street, #308
Key West, FL 33040
305 / 292-6810

4. The name, address, and telephone number of the representative of the provider responsible for administration of the program under this contract is:
Deloris Simpson
Monroe County In Home Services
1100 Simonton Street
Key West, FL 33040
305 / 292-4589

5. Upon change of representatives (names, addresses, telephone numbers) by either party, notice shall be provided in writing to the other party and the notification attached to the originals of this contract.

F. All Terms and Conditions Included
This contract and its attachments, I, II and Exhibits A, B, C, D, E and F, and any exhibits referenced in said attachments, together with any documents incorporated by reference, contain all the terms and conditions agreed upon by the parties. There are no provisions, terms, conditions, or obligations other than those contained herein, and this contract shall supersede all previous communications, representations, or agreements, either verbal or written between the parties. If any term or provision of this contract is legally determined unlawful or unenforceable, the remainder of the contract shall remain in full force and effect and such term or provision shall be stricken.

By signing this contract, the parties agree that they have read and agree to the entire contract, as described in Paragraph III.F. above.

IN WITNESS THEREOF, the parties hereto have caused this 91 page contract to be executed by their undersigned officials as duly authorized.

PROVIDER:
Monroe County (Monroe County In Home Services)

(SEAL)
ATTEST: DANNY L. KOLHAGE CLERK
BY: _____ DEPUTY CLERK

SIGNED BY: Murray E. Nelson
NAME: Murray E. Nelson
TITLE: Mayor
DATE: June 16, 2004

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES

SIGNED BY: Charles M. Hood, III (or)
NAME: Charles M. Hood III
TITLE: District Administrator
DATE: 6/24/04

STATE AGENCY 29 DIGIT FLAIR CODE: _____

Federal EID # (or SSN): 59-6000749

Provider Fiscal Year Ending Date: 9/30

MONROE COUNTY ATTORNEY
APPROVED AS TO FORM
SUZANNE A[illegible]TTON
ASSISTANT COUNTY ATTORNEY

APPROVED AS TO FORM
AND LEGAL SUFFICIENCY
[illegible] 5/26/04

CONTRACT # KG051

ATTACHMENT I

A. Services to be Provided

1. Definition of Terms

a. Contract Terms

Refer to the Glossary in CFOP 75-2, Contract Management System for Contractual Services, which is incorporated by reference herein

b. Program or Service Specific Terms

(1) Activities of Daily Living - Basic activities performed in the course of daily living, such as dressing, bathing, grooming, eating, using a commode or urinal, and ambulating around one's own home.

(2) Client - Any person who is eligible and is at least eighteen (18) years through age fifty-nine (59), has one (1) or more permanent physical or mental limitations that restrict the client's ability to perform normal activities of daily living, and impede the client's capacity to live independently or with relatives or friends without the provision of community-based services.

(3) The Community Care for Disabled Adults program (CCDA) – A program based on a brokerage of community and in-home services for functionally challenged adults with disabilities.

(4) Institutional Care Program (ICP) – A state program that provides financial supplements to disabled adults and elderly who are determined eligible for a nursing home level of care.

(5) Nursing Home - Any facility which provides nursing services as defined in Chapter 464, Florida Statutes (F.S.), which is licensed in accordance with Chapter 400, F. S.

(6) Outcomes – Quantitative indicators that can be used by the department to objectively measure a provider's performance toward a stated goal.

(7) Outputs – Process measures of the quantity(ies) of services delivered, clients served, or similar units completed.

(8) Performance Measures - Quantitative indicators, outcomes and outputs, that can be used by the department to objectively measure a provider's performance.

(9) CCDA Operating Procedure, CFOP 140-8 - A publication developed by the department to better assist department staff and acquaint contract provider staff with the types of services the department purchases for its clients, and the scope of those services as established by policy. Hereafter, the publication is referred to as, "the CCDA Operating Procedure."

2. General Description

a. General Statement

(1) The Community Care for Disabled Adults (CCDA) program is designed to assist disabled adults, age eighteen (18) through fifty-nine (59), in utilizing available community and personal resources enabling them to remain in their own homes, and preventing their premature or inappropriate institutionalization.

(2) Service providers will ensure that appropriate community-based services are provided to clients in a manner designed to meet the client's changing needs, to assist the client in avoiding or reducing unnecessary dependence on the delivered service(s), and to increase the client's self-reliance.

b. Authority

Sections 410.601-606, and 20.19 F. S., Chapter 65C-2, Florida Administrative Code (F.A.C.), and the annual appropriations act, with any proviso language or instructions to the department, constitute the legal basis for services to be delivered through the CCDA program.

c. Scope of Service

Services will be targeted toward eligible adults, age eighteen (18) through fifty-nine (59), in Monroe County.

d. Major Program Goal

Community-based services provided under this contract are designed to prevent inappropriate institutionalization of disabled adults.

3. Clients to be Served

a. General Description

CCDA eligible adults with disabilities, age eighteen (18) through fifty-nine (59), who are no longer eligible to receive children's services, and are too young to qualify for community and home-based services for the elderly, may be served under the provisions of this contract.

b. Client Eligibility

(1) Applicants must have one (1) or more permanent physical or mental limitations, that restrict the ability to perform normal activities of daily living, as determined through the initial functional assessment and medical documentation of disability. Determination of a permanent disability must be established and evidenced in one of the following manners:

(a) An applicant may present a check, award letter, or other proof showing receipt of Social Security Disability Income, or some other disability payment (e.g., Worker's Compensation); or

(b) An applicant may present a written statement from a licensed physician, licensed nurse practitioner, or mental health professional,

which meets the district's criteria for evidence of a disability. This written statement must, at a minimum, include the applicant's diagnosis, prognosis, a broad explanation of level of functioning, and the interpretation of need for services based on identified functional barriers caused by the applicant's disabling condition.

(2) Applicants must have an individual income at or below the prevailing ICP eligibility standard in order to receive free CCDA services.

(3) Applicants with incomes above the ICP standard will be assessed for a share of the costs, or may be required to provide volunteer services in lieu of payment.

c. Client Determination

(1) Clients will be assessed for eligibility determination, and prioritized for services by the department or provider case management staff, in accordance with subsection 410.604 (2), F.S.

(2) The department's program manager will make the final determination in the event of a dispute regarding client eligibility.

d. Contract Limits

(1) The total annual cost estimated or actual, for an individual receiving CCDA services, shall not exceed the average, annual general revenue portion of a Medicaid nursing home bed within the district area.

(2) Clients must not be receiving comparable services from any other entity. In order to prevent duplication of services, client files must contain documentation verifying that all comparable community services and funding sources have been explored and exhausted.

(3) The provider shall deliver services only to those persons who meet program eligibility criteria, and only to the extent that funds are available.

B. Manner of Service Provision

1. Service Tasks

a. Task List

(1) The following tasks will be performed under this contract:

- Case Management
- Homemaking
- Home Delivered Meals
- Personal Care

(2) Details of services to be provided under this contract and the negotiated parameters of those services not found in the CCDA Operating Procedure, **Exhibit A,** may be listed here: N/A

b. Task Limits

The following are limits applicable to specific service(s) purchased through this contract, as specified above.

(1) Each district CCDA program shall include case management services and at least one(1) other community service.

(2) Respite Care services may be provided for up to two hundred forty (240) hours per client per calendar year, depending upon individual need. The service may be extended to three hundred sixty (360) hours, as recommended by the case manager and approved by an immediate supervisor. Documentation of approval must be evident in the case narrative section of the case manager's file.

(3) Personal Care services will not substitute for the care usually provided by a registered nurse, licensed practical nurse, therapist, or home health aide. The personal care aide will not change sterile dressings, irrigate body cavities, administer medications, or perform other activities prohibited by Chapter 59A-8, F.A.C.

(4) Homemaker service time does not include time spent in transit to and from the client's place of residence except when providing shopping assistance, performing errands or other tasks on behalf of a client.

(5) Several restrictions apply to persons providing Homemaker service activities. Persons providing services **must not**:

(a) engage in work that is not specified in the Homemaker assignment;

(b) accept gifts from clients;

(c) lend to or borrow money or personal possessions from clients;

(d) handle client money, unless authorized in writing by a supervisor or case manager (as evident in the personnel file) and unless bonded or insured by the employer; or

(e) transport clients, unless authorized in writing by a supervisor or case manager.

(6) The parameters of service delivery, by type of service, are detailed in the CCDA Operating Procedure, **Exhibit A.**

2. Staffing Requirements

a. Staffing Levels

(1) The provider will meet the minimum staffing requirements for each service, as specified in the CCDA Operating Procedure, **Exhibit A.**

(2) The provider will notify the department, in writing, within thirty (30) days whenever the provider is unable, or expects to be unable to provide the required quality or quantity of service because of staff turnovers or shortages.

b. Professional Qualifications

The provider will ensure that staff meets the professional qualifications for each service, as specified in the CCDA Operating Procedure, **Exhibit A.**

c. Staffing Changes

The provider agrees to notify the department's contract manager within two (2) working days if a key administrative position (e.g., executive director) becomes vacant. Planned staffing changes that may affect service delivery, as stipulated in this contract, must be presented in writing to the contract manager for approval at least two (2) weeks prior to the implementation of the change.

d. Subcontractors

This contract allows the provider to subcontract for the provision of all services under this contract. All subcontracting is subject to the provisions of Section I.I. of the Standard Contract.

3. Service Location and Equipment

a. Service Delivery Location and Times

(1) CCDA services may be delivered in the client's home or on-site at a facility, as negotiated by the department and the provider.

(2) Facilities delivering on-site services to clients shall pass an annual inspection by the local environmental health and fire authorities.

(3) Service providers will meet the minimum service location and time requirements as specified in the CCDA Operating Procedure, **Exhibit A.**

(4) Services for this contract will be delivered at the following locations and times:

SERVICE	LOCATION	TIME(S)
Case Management	Client's Home	As Needed
Home Delivered Meals	Client's Home	As Needed
Homemaking	Client's Home	As Needed
Personal Care	Client's Home	As Needed

b. Changes in Location

The provider must notify the department of changes in the location of service delivery. Once the service delivery location is agreed upon, any proposed change must be presented in writing to the contract manager for approval, ten (10) days prior to implementation of that proposed change. In the event of an emergency, temporary changes in location may necessitate waiver of this designated standard by the district's program office. Such a waiver will take into consideration the continuity, safety, and welfare of the department's clients, and is at the department's sole discretion.

c. Equipment

(1) When equipment is applicable to service(s) provided through this contract the provider must submit an Equipment, Exhibit N/A, to the department. The equipment required to perform the contracted services must be negotiated by the department and

the provider. To ensure uniformity, safety, and quality of service to clients, any requests for equipment changes must be presented in writing to the contract manager for approval at least ten (10) days prior to any proposed change.

(2) The provider must inventory all equipment acquired under this contract annually. The inventory list must be made available within seven (7) days upon receipt of written request by the contract manager. The provider must list the items of equipment on the Equipment, Exhibit N/A, as applicable to the provider's contract for specific services.

4. Deliverables

a. Service Units

A service unit is an appropriate, distinct amount of given service, which may include, but is not limited to, an hour or quarter hour of direct service delivery; a meal; an episode of travel; or a twenty-four (24) hour period of Emergency Alert Response maintenance, as defined in the CCDA Operating Procedure, **Exhibit A.** All service units, as well as their description, are listed in the CCDA Operating Procedure, **Exhibit A.**

b. Records and Documentation

(1) Case Management provider files shall contain the following:

(a) a completed client assessment (not more than one (1) year old);

(b) a care plan (not more than one (1) year old);

(c) a release of information form;

(d) a copy of an official data entry client information form;

(e) documentation of the client's age, disability, and income;

(f) a completed and scored Adult Services Screening for Consideration for Services Form; and

(g) a case narrative.

(2) Providers shall maintain information on each client served by this contract, which includes the following:

(a) documentation of the client by name or unique identifier;

(b) current documentation of eligibility for services;

(c) dates of service provision and delivery;

(d) information documenting the client's need to receive services;

(e) the number of service units provided; and

(f) all other forms or records necessary for program operation and reporting, as set forth by the department.

(3) Providers must ensure that all client records accurately match the invoices submitted for payment. Client records must cross reference to each invoice for payment.

(4) Providers must maintain documentation necessary to facilitate monitoring and evaluation by the department.

(5) The case management provider must maintain documentation in the client's file that all comparable community services and funding sources have been explored and exhausted before using CCDA funding.

c. Reports

Report Title	Reporting Frequency	Report Date Due	Number of copies due	DCF Office address to receive report
Quarterly Cumulative Summary Reports	Quarterly	10/30/04 02/15/05 04/30/05 08/15/05	One	Contract Manager
Performance Data Report	Monthly	10th of the month following the report period	One	Contract Manager
Active Client Log	Monthly	10th of the month following the report period	One	Contract Manager
Wait List Log	Monthly	10th of the month following the report period	One	Contract Manager
Client Cost Plans	Updated Monthly	10th of the month following the report period	One	Contract Manager
Cost Report	Monthly	10th of the month following the report period	One	Contract Manager

(1) Reporting requirements for this contract include, **Exhibit B**, Quarterly Cumulative Summary Reports, if applicable. Districts will negotiate with the provider on specific submission requirement criteria for these reports.

(2) Providers of case management services agree to submit Quarterly Cumulative Summary Reports, which include management program data (e.g., client identifiable data) to the department, according to negotiated instructions provided by the districts.

(3) In the event of early termination of this contract, the provider will submit the final Quarterly Cumulative Summary Report within forty-five (45) days after the contract is terminated.

(4) The provider agrees to submit a monthly Cost Report, **Exhibit C**, which details the number of units of service provided to each client during the report period.

(5) The provider agrees to submit all other reports indicated above in formats to be determined by the provider.

5. Performance Specifications

a. Performance Measures

100% of disabled adults served through this contract are receiving CCDA provided case management.

b. Description of Performance Measurement Terms

Approved CCDA Case Management Agency – The agency that the department has contracted for case management services for the individual clients being serviced through this contract.

c. Performance Evaluation Methodology

(1) Measuring Outcomes. The department will measure the outcomes found in paragraph B.5.a. above as follows:

The outcome measurement contained in paragraph B.5.a. (1) above will be measured by dividing the fiscal year-to-date number of clients receiving services from this contracted provider, receiving CCDA funded case management service(s), by the fiscal year-to-date number of all clients receiving services from this contracted provider.

(2) By execution of this contract the provider hereby acknowledges and agrees that its performance under the contract must meet the standards set forth above and will be bound by the conditions set forth in this contract. If the provider fails to meet these standards, the department, at its exclusive option, may allow up to six (6) months for the provider to achieve compliance with the standards. If the department affords the provider an opportunity to achieve compliance and the provider fails to achieve compliance within the specified time frame, the department must cancel the contract in the absence of any extenuating or mitigating circumstances. The determination of the extenuating or mitigating circumstances is the exclusive determination of the department.

6. Provider Responsibilities

a. Provider Unique Activities

(1) The provider will be required to use volunteers to the fullest extent feasible in the provision of services and program operations. The provider is required to train, supervise, and appropriately support all volunteers with insurance coverage.

(2) The provider will refer all individuals requesting CCDA service(s) to and provide them with the telephone number of the nearest Adult Services unit within the district/region for each individual to make contact with a departmental counselor and complete a screening for consideration for service.

(3) If required by 45 CFR Parts 160, 162, and 164, the following provisions shall apply [45 CFR 164.504(e)(2)(ii)]:

(a) The provider hereby agrees not to use or disclose protected health information (PHI) except as permitted or required by this contract, state or federal law.

(b) The provider agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this contract or applicable law.

(c) The provider agrees to report to the department any use or disclosure of the information not provided for by this contract or applicable law.

(d) The provider hereby assures the department that if any PHI received from the department, or received by the provider on the department's behalf, is furnished to provider's subcontractors or agents in the performance of tasks required by this contract, that those subcontractors or agents must first have agreed to the same restrictions and conditions that apply to the provider with respect to such information.

(e) The provider agrees to make PHI available in accordance with 45 CFR 164.524.

(f) The provider agrees to make PHI available for amendment and to incorporate any amendments to PHI in accordance with 45 CFR 164.526.

(g) The provider agrees to make available the information required to provide an accounting of disclosures in accordance with 45 CFR 164.528.

(h) The provider agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from the department or created or received by the provider on behalf of the department available for purposes of determining the provider's compliance with these assurances.

(i) The provider agrees that at the termination of this contract, if feasible and where not inconsistent with other provisions of this contract concerning record retention, it will return or destroy all PHI received from the department or received by the provider on behalf of the department, that the provider still maintains regardless of form. If not feasible, the protections of this contract are hereby extended to that PHI which may then be used only for such purposes as to make the return or destruction infeasible.

(j) A violation or breach of any of these assurances shall constitute a material breach of this contract.

b. Coordination with Other Providers/Entities

The case management provider must coordinate, as necessary, with the Developmental Disabilities Program Office of the Department of Children and Families, the Department of Education, the Department of Health, and the Florida Statewide Advocacy Council, to serve those clients who are eligible for services through two (2) or more service delivery continuums.

7. Departmental Responsibilities

a. Department Obligations

The department will provide CCDA technical assistance to the provider, relative to the negotiated terms and conditions of this contract and instructions for submission of required data.

b. Department Determinations

Should a dispute arise, the department will make the final determination as to whether the contract terms and conditions are being fulfilled according to the contract specifications.

c. Monitoring Requirements

The provider will be monitored in accordance with existing departmental procedures (CFOP 75-8).

(1) By execution of this contract, the provider hereby acknowledges and agrees that its performance under the contract must meet the standards set forth above and will be bound by the conditions set forth below. If the provider fails to meet these standards, the department, at its exclusive option, may allow up to six months for the provider to achieve compliance with the standards. If the department affords the provider an opportunity to achieve compliance, and the provider fails to achieve compliance within the specified time frame, the department will terminate the contract in the absence of any extenuating or mitigating circumstances. The determination of the extenuating or mitigating circumstances is the exclusive determination of the department.

(2) The Contract Performance Unit ("CPU") may elect to perform an on-site administrative and programmatic monitoring during the contract period. At a minimum, an annual desk monitoring will be performed which will be accomplished by a combination of the review(s) of reports or other documentation submitted by the provider, input from service recipients and others, and visits to the site of service delivery for programmatic review.

(3) For on-site monitorings, a random discovery sample of open and closed files will be taken for review. This sample may be increased to a random statistical sample depending on the results of our review. The number of files reviewed will be contingent upon the population size of services rendered. To facilitate the sampling process, upon CPU request, the provider shall submit a universal events listing of all services provided under the contract prior to the monitoring visit.

(4) A report outlining the department's findings during the on-site monitoring will be submitted to the provider within 30 days of concluding field work with an exit conference. The provider agrees to respond and submit a corrective action plan, if required, within 30 days of receiving the department's monitoring report.

C. Method of Payment

1. Payment Clause

a. This is a Fixed Price contract. The department shall pay the provider for the delivery of service units provided in accordance with the terms and conditions of this contract for a total dollar amount not to exceed $83,599.00, subject to the availability of funds.

b. The department shall make payments to the provider for provision of services up to the maximum number of units of service at the rates shown below.

Service Units	Unit Price	Maximum # of Units
Case Management	$47.73	228
Homemaking	$27.11	1517
Home Delivered Meals	$ 5.10	4000
Personal Care	$51.11	219

c. The provider's dollar match for this contract is $9,288.78. Case management and transportation services may be exempt from match requirement at the discretion of each district.

d. Cash or in kind resources may be used to meet this match requirement.

2. Invoice Requirements

The provider shall request payment through submission of a properly completed Invoice, **Exhibit D,** within 10 days following the end of the month for which payment is being requested. The provider shall submit to the contract manager an original Invoice, **Exhibit D,** and no copies, along with supporting documentation. Payment due under this contract will be withheld until the department has confirmed delivery of negotiated services.

3. Supporting Documentation

a. It is expressly understood by the provider that any payment due under the terms and conditions of this contract may be withheld pending the receipt and approval by the department of all financial and program reports due as a part of this contract, and any adjustments thereto. Requests for payment, which cannot be documented with supporting evidence, will be returned to the provider upon inspection by the department.

b. The provider must maintain records documenting the total number of recipients and names (or unique identifiers) of recipients to whom services were provided and the dates the services were provided so that an audit trail documenting service provision can be maintained.

D. Special Provisions

1. Fees

a. The provider will collect fees for services provided according to Rule 65C-2.007, F.A.C.

b. No fees shall be assessed other than those established by the department. Fees collected in compliance with the department directives will be reinvested in a manner prescribed by the department.

2. Florida Statewide Advocacy Council

The provider agrees to allow properly identified members of the Florida Statewide Advocacy Council access to the facility or agency and the right to communicate with any client being served, as well as staff or volunteers who serve them in accordance with subsections 402.165(8) (a) & (b), F.S. Members of the Florida Statewide Advocacy Council shall be free to examine all records pertaining to any case unless legal prohibition exists to prevent disclosure of those records.

3. MyFloridaMarketPlace Transaction Fee

The State of Florida, through the Department of Management Services, has instituted MyFloridaMarketPlace, a statewide eProcurement system. Pursuant to subsection 287.057(23), Florida Statutes (2002), all payments shall be assessed a Transaction Fee of one percent (1.0%), which the provider shall pay to the State.

For payments within the State accounting system (FLAIR or its successor), the Transaction Fee shall, when possible, be automatically deducted from payments to the provider. If automatic deduction is not possible, the provider shall pay the Transaction Fee pursuant to Rule 60A-1.031(2), Florida Administrative Code. By submission of these reports and corresponding payments, provider certifies their correctness. All such reports and payments shall be subject to audit by the State or its designee.

The provider shall receive a credit of any Transaction Fee paid by the provider for the purchase of any item(s) if such item(s) are returned to the provider through no fault, act, or omission of the provider. Notwithstanding the foregoing, a Transaction Fee is non-refundable when an item is rejected or returned, or declined, due to the provider's failure to perform or comply with specifications or requirements of the agreement.

Failure to comply with these requirements shall constitute grounds for declaring the provider in default and recovering procurement costs from the provider in addition to all outstanding fees. **PROVIDERS DELINQUENT IN PAYING TRANSACTION FEES MAY BE EXCLUDED FROM CONDUCTING FUTURE BUSINESS WITH THE STATE.**

4. Transportation Disadvantaged

The provider agrees to comply with the provisions of Chapter 427, F.S., Part I, Transportation Services, and Chapter 41-2, F.A.C., Commission for the Transportation Disadvantaged, if public funds provided under this contract will be used to transport clients.

5. Information Technology Resources.

All contract providers must adhere to the Department's procedures and standards when purchasing Information Technology Resources (ITRs) as part of this contract. These resources will revert to the Department at the conclusion of the contract. ITRs are data processing hardware, software, service, supplies, maintenance, training, personnel, and facilities. The provider agrees to secure prior written approval through the contract manager from the District Management Systems Director for the purchase of any ITR. The provider will not be reimbursed for any purchase made prior to this written approval.

6. Morals Clause

The provider understands that performance under this contract involves the expenditure of public funds from both the state and federal governments, and that the acceptance of such funds obligates the provider to perform its services in accordance with the very highest standards of ethical and moral

conduct. Public funds may not be used for purposes of lobbying, or for political contributions, or for any expense related to such activities, pursuant to Section I R of the Standard Contract of this contract. The provider understands that the Department is a public agency which is mandated to conduct business in the sunshine, pursuant to Florida Law, and that all issues relating to the business of the Department and the provider are public record and subject to full disclosure. The provider understands that attempting to exercise undue influence on the Department and its employees to allow deviation or variance from the terms of this contract other than negotiated, publicly disclosed amendment, is prohibited by the State of Florida, pursuant to Section III C of the Standard Contract. The provider's conduct is subject to all state and federal laws governing the conduct of entities engaged in the business of providing services to government.

7. Employee Loans
Funds provided by the Department under this contract shall not be used by Not-For-Profit Corporations to make loans to their employees, officers, directors and/or subcontractors. Violation of this provision shall be considered a breach of contract, the termination of this contract shall be in accordance with the Standard Contract, Section III, Paragraph B, Subsection 3. A loan is defined as any advance of money for which the repayment period extends beyond the next scheduled pay period.

8. Emergency Plan
The provider shall be responsible for the care, maintenance and, if necessary, the relocation of clients during any natural disaster or period of civil unrest. The provider shall submit its emergency plan to the Department for approval at the time of submission of the agency's proposal and must be updated annually.

9. Incident Reporting
The Provider is required to document all reportable incidents, as defined in the District 11 Uniform Incident Reporting Protocol for Incident Reporting and Client Risk Prevention For Critical and Non-Critical Incidents, which is incorporated herein by reference.

For each critical incident occurring during the administration of its program, the Provider must, within 24 hours of the incident, complete and submit the District's approved Incident Report form **(Exhibit E)** to the respective department program incident report liaison. The incident report liaison for this contract is Al Papa, 401 NW 2nd Avenue, Suite N-1007, Miami, FL 33128. It is the Provider's responsibility to use the most current District 11 approved incident report for this purpose. A copy of the incident report must also be placed in a central file marked "Confidential Incident Report". Dissemination of the report within the department will be the responsibility of the department's program incident report liaison.

Incidents that threaten the health, safety or welfare of any person or that place any person in imminent danger must be reported immediately to the department by telephonic contact.

The information contained in the incident report is confidential. The dissemination, distribution or copying of the report is strictly prohibited, unless authorized by the Department.

10. Security Agreement Form
The provider agrees to submit to the Department Contract Manager an original signed Security Agreement Form (CF-114) **(Exhibit F)** for all required personnel no later than thirty (30) days following the execution of this contract or thirty (30) days from date of employment. All personnel who require access to departmental information must sign the Security Agreement Form prior to receiving access to the information.

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, May 15, 2003

CF OPERATING PROCEDURE
NO. 140-8

Adult Services

COMMUNITY CARE FOR DISABLED ADULTS

This operating procedure describes the Community Care for Disabled Adults Program administered by the department.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

CELESTE PUTNAM
Acting Assistant Secretary for Programs

SUMMARY OF REVISED, DELETED, OR ADDED MATERIAL

This operating procedure has been updated to reflect the current requirements for the Community Care for Disabled Adults program.

CONTENTS

This operating procedure supersedes HRSM 140-8 dated September 2, 1986 and HRSM 140-8A dated March 1, 1987.
OPR: PDAS
DISTRIBUTION: X: OSES; OSLS; ASGO; PDAS; DASGS(D1-15); District Adult Services staff.

CONTENTS (continued)

Paragraph

CONTENTS (continued)

Paragraph

Chapter 1
INTRODUCTION TO THE COMMUNITY CARE FOR DISABLED ADULTS PROGRAM

1-1. Purpose.

a. This operating procedure is the Department of Children and Family Services' program document for the Community Care for Disabled Adults (CCDA) program.

b. The operating procedure provides district/region staff and contract providers with fiscal and programmatic requirements for implementation of the Community Care for Disabled Adults' policy, rule and statutory requirements.

1-2. Legal Base. The legal bases for the Community Care for Disabled Adults Program are Chapters 410.602-606 and 20.19(4)(b)2.d., F.S., and the annual appropriations act with any proviso or instructions to the department.

1-3. Funding. The Community Care for Disabled Adults program is currently funded by general revenue funds. These funds are allocated to the fifteen Adult Services district and region offices according to an allocation formula using the United States Department of Commerce's Census disability statistics for the State of Florida comparing disabled adults per district to the total number of disabled adults in the state. The Department of Children and Families must ensure that all available funding sources have been explored prior to using funds allocated to this program.

1-4. History. In 1984, the Community Care for Disabled adults program was established in statute to provide disabled adults, age 18 through 59, in-home services needed to help them remain in their own homes in the community and prevent institutionalization.

1-5. Services.

a. The program is based on a brokerage of service approach for functionally challenged adults with disabilities. Services contracted through the Community Care for Disabled Adults Program include:

(1) Adult day care;

(2) Adult day health care;

(3) Chore, such as house or yard work that doesn't require specialized staff;

(4) Case management, which is coordination of services among programs;

(5) Emergency alert response to monitor a person's safety at home;

(6) Escort services for someone to accompany the client to and from services;

(7) Group activity therapy;

(8) Home delivered meals;

(9) Homemaker;

(10) Interpreter to provide help for clients with communication impairments;

(11) In-home nursing services;

(12) Personal care;

(13) Respite care;

(14) Transportation;

(15) Medical equipment; and,

(16) Home health aide services.

b. Transitional mental health counseling is also available to help disabled persons adjust to the onset of a disability and to cope with financial, legal and other personal problems.

1-6. The Community Care For Disabled Adults Client.

a. The Community Care for Disabled Adults program provides a link to community resources which help disabled adults to remain as productive and comfortable as possible, while enabling them to remain in their own homes for as long as possible. The program provides options for disabled adults that would otherwise not be available to them.

b. Many participants of the Community Care for Disabled Adults Program have disabilities which range from heart conditions and hypertension to arthritis and paralysis, to amputation and multiple sclerosis. Some were stricken with diseases like muscular dystrophy or polio. Whatever the cause, the victims of accidents, diseases or birth defects rely on family, friends and the kindness of others to help them maintain their independence in the community. For many, Community Care for Disabled Adults is the cornerstone of local care. It plays a vital role in providing adults with disabilities with long-term supports. It provides them with in-home services and empowers them to maintain their independence and remain in their own homes. Because the program is designed to serve totally and permanently disabled persons who are not eligible for assistance from other programs, it fills the gap in the service delivery continuum for adults with disabilities. It is the only state-funded community service program that provides in-home services to adults with circulatory disorders, cancer and multiple sclerosis.

Chapter 2

DEFINITIONS AND SCOPES OF APPROVED SERVICES

2-1. Purpose. The purpose of this chapter is to list and define the approved Community Care for Disabled Adults (CCDA) services and the minimum training and staffing standards for these services.

2-2. Adult Day Care (ADC).

a. Service Definition and Unit of Measure.

(1) Adult day care means a planned social program that provides a protective environment where supervision for the health, safety and well-being of adults who have functional impairments is provided.

(2) A unit of service is one hour of actual client attendance at the day care center. The travel time to and from the center is not counted in the daily attendance.

(3) Adult Day Care centers must be licensed by the Agency for Health Care Administration in accordance with Chapter 400, Part V, F.S., and services administered according with Chapter 58A-6, F.A.C., the Adult Day Care rule.

b. Minimum Service Standards.

(1) To be licensed as an Adult Day Care Center, the following minimum basic services must be provided:

(a) A supervised, protective environment that promotes a non-institutional atmosphere;

(b) A variety of therapeutic, social and health activities and services (such as exercise, health screening, health education, interpersonal communication and behavior modification) which help to restore, remediate, or maintain optimal client functioning and increase client interaction;

(c) Leisure time activities designed to cultivate client self-expression, self-esteem and mental stimulation;

(d) Self-care training activities;

(e) Individualized rest periods or periods of relaxation or inactivity during the day;

(f) Nutritional services (meals/snacks); and,

(g) In-facility respite care for a functionally impaired adult for the purpose of relieving the primary caregiver.

(2) Adult day care centers, contracted with CCDA funds, offering the following OPTIONAL services must meet these service standards:

(a) Therapies. These services must be administered by staff qualified to provide such services and within the criteria established by relevant Florida Statutes.

1. Occupational Therapy as an adjunct to treatment for persons with physical and mental limitations will be provided by or under the supervision of an individual who is registered by the American Occupational Therapy Association, or a graduate of a program of occupational therapy approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

2. Physical Therapy will be provided by or under the supervision of an individual who is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Therapy association, or the equivalent and licensed by the State.

3. Speech Therapy will be provided by or under the supervision of an individual licensed under Chapter 468, Part I, F.S., who has certification of clinical competence from the American Speech and Hearing Association, and who has completed the equivalent educational requirements and work experience necessary for certification, or who has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(b) Transportation. Transportation services consist of conveying participants from home to the adult day care center and return home. If the day care center does not provide transportation directly, arrangements must be made with available transportation providers. The client's physical limitation(s) must be considered when planning for transportation. Wheelchair clients may require an appropriately equipped vehicle. Provisions must be made to assist persons in getting on or off the vehicle, if needed.

(c) Nursing Service. Nursing service by a licensed registered nurse or licensed practical nurse, currently licensed in Florida, includes, but is not limited to: screening procedures for chronic diseases (e.g., hypertension, or diabetes); observation, assessment, and monitoring of clients health needs and daily functioning levels; administration or supervision of medications or treatments; counseling for participant, family or caregiver in matters relating to health and prevention of illness; and referral to other community resources with follow-up of suspected physical, mental, or social problems requiring definitive resolution.

c. Minimum Staffing Standards.

(1) Nursing Staff. A registered or licensed practical nurse, licensed by the State of Florida, must be on duty at the site during primary hours of program operation and available at other times.

(a) When the position is filled by a licensed practical nurse, this person must work under the supervision of a Registered Nurse.

(b) The registered or licensed practical nurse must be on duty at the site during the primary hours of program operation. If the nurse leaves the site, the administrator must be on the premises during the center's hours of operation.

(2) First Aid Certified Staff. No less than 2 certified staff persons must be on duty at the site during primary hours of program operation.

(a) These staff persons must be certified in an approved first aid course and Cardio-Pulmonary Resuscitation (CPR) training.

(b) These staff persons must be capable of recognizing symptoms of distress in this client population and must be at the center at all times.

(3) Center Director. The following major functions and duties, additional to those outlined in Chapter 58A-6, Florida Administrative Code, may be delegated to managerial staff but remain the responsibility of the Center Director:

(a) Recruits, screens and trains staff of facility;

(b) Plans and provides organized programs of pre-service and in-service training for staff;

(c) Interprets policies and procedures to staff and clients;

(d) Ensures integration and coordination between program and appropriate community resources;

(e) Maintains close supervision of staff in the following areas of operation: secretarial and bookkeeping; housekeeping; maintenance; transportation; food services; consulting services; and direct services;

(f) Evaluates the performance of each staff member;

(g) Assures accurate and timely completion of all records and reports, including those required for the Client Information System (CIS); and,

(h) Maintains program statistical data and records as required.

d. Minimum Training Standards.

(1) Policy training topics must include; medical record keeping, Adult Day Health Care policies and procedures, and monitoring for change (such as medical, psychological and social, and physiological changes with age and chronic diseases).

(2) Medical training topics must include; medical emergency procedures, rehabilitation therapies, and prescription drugs common to this population, as well as the interaction of those common drugs.

2-3. Adult Day Health Care (ADHC).

a. Service Definition and Unit of Measure.

(1) Adult day health care means an organized day program of therapeutic, social and health activities and services provided to disabled adults for the purpose of restoring or maintaining optimal capacity for self care.

(2) A unit of service is equal to one hour of actual client attendance at the adult day health care center, including travel to or from the center if the adult day care center is providing the transportation with CCDA funds.

b. Minimum Operating Standards. Each center must provide services for a minimum of five hours per day, five days per week.

c. Minimum Service Standards. To be licensed as an adult day health care center, in addition to the basic services specified for an adult day care center, the adult day health center must provide or coordinate:

(1) Medical Services. Medical services can be provided by either the personal physician or advanced registered nurse practitioner of the client, a staff physician, or both, and must emphasize preventive treatment, rehabilitation, and continuity of care and also provide for maintenance of adequate medical records. An advanced registered nurse practitioner in accordance with protocols established in collaboration with the personal physician of the client or the site staff physician may supervise the health needs of clients.

(2) Medical Therapeutic/Rehabilitative Services. Medical therapeutic/rehabilitative services appropriate to the needs of the client must be provided by a contractor or by on-site staff and progress notes kept current.

(a) Physical Therapy. Progress notes must be written in the client's record and signed by the physical therapist as services are provided.

(b) Occupational Therapy. Progress notes must be written in the client's record and signed by the occupational therapist as services are provided.

(c) Speech Therapy. Progress notes must be written in the client's record and signed by the speech therapist as services are provided.

(3) Nursing. Nursing services must be rendered by registered nurses (RN) or licensed practical nurses (LPN) who work under the supervision of a registered nurse. Such nurses must evaluate quarterly, at a minimum, the particular needs of each client and provide for their care and treatment. Care and treatment will include medication supervision, health education and counseling, nutritional advice, act as a liaison with the participant's personal physician and caregiver or family, coordinate provision of all other needed health services, and supervision of self-care services oriented toward activities of daily living and personal hygiene as provided by program aides in this service area. Narrative nursing notes must be entered in the client's medical record at least weekly indicating the individual's progress toward achieving health goals. More frequent notes are required if indicated by the client's condition.

(4) Social Work Services. Social work services to assist with personal, family and other problems that interfere with the effectiveness of treatment must be provided to clients and their families. Social services include a compilation of a social history and psychosocial assessment of formal and informal support systems, mental and emotional status, caregiver data, and information for planning for discharge. These services will be provided by the social work staff employed by the adult day care center and are not to be confused with the case management responsibilities of the CCDA case manager. [The CCDA case manager will complete the functional assessment of the client, will counsel in the development of a service plan, will arrange for services, and will provide ongoing monitoring of the client's situation to ensure that needed services are received].

(5) Transportation Services. Transportation from the client's home to the center and back home again, must be a function of the program. If the center does not provide transportation directly, arrangements for day care participants needing transportation must be established. The cost of this transportation is included in the rate paid to the contracted provider of the adult day health care service. The client's physical limitation(s) must be considered when planning for transportation. Wheelchair clients may require an appropriately equipped vehicle. There must be an escort on a bus or van to assist persons in getting on and off the vehicle when needed.

(6) Additional Medical Services. Dental, ophthalmology, optometry, hearing aid, and laboratory services will be offered.

d. Minimum Staffing Standards. In addition to the minimum staffing required for an adult day care center, the adult day health care center will provide the following staff:

(1) Nursing Staff. A registered nurse (RN) or licensed practical nurse (LPN) will be on site during the primary hours of program operation and on-call during all the hours the center is open. Arrangements will be

formalized for obtaining the services of an RN or LPN in anticipation of potential absences, planned and unplanned, of the regular nursing staff. All LPN's must be supervised in accordance with Chapter 464, F.S.

(2) Social Worker. A social worker with a minimum of a Bachelor's degree in social work, sociology, psychology or nursing or a Bachelor's degree with at least 2 years of experience in a human service field. Services provided by program aides in this service area must be provided under the direct supervision of a social worker or of a case manager who meets or exceeds these standards (e.g., a Masters degree in a related field).

(3) Recreational Therapist. An activity director or recreational therapist with a Bachelor's degree in a social or health service field or an Associate's degree in a related field plus 2 years of experience. All services provided by program aides must be provided under the direct supervision of the activity director or recreational therapist. The certified recreation therapist may be retained as a consultant.

(4) Center Operator/Director. The Operator/Director will have a minimum of a Bachelor's degree in a health or social services or related field with one year of supervisory experience in a social or health service setting or hold an RN license with one year of supervisory experience or have five years of supervisory experience in a social or health service setting.

2-4. Case Management.

a. Service Definition and Unit of Measure.

(1) Case management means a client centered series of activities which includes planning, arrangement for and coordination of appropriate community-based services for an eligible Community Care for Disabled Adult client and is an approved services, even when delivered in the absence of other services. It includes intake and referral, comprehensive assessment, development of a service plan, arrangement for service and monitoring of client's progress to assure the effective delivery of services and reassessment.

(2) A unit of service is one hour of elapsed time involved in the above-described case management activities.

b. Minimum Position Qualifications.

(1) Contracted case managers must possess a Bachelor's degree in social work, sociology, psychology, nursing, or related field. Other directly related job education or experience may be substituted for all or some of these basic requirements upon approval of the district/region Adult Services program office.

(2) Departmental case managers must be qualified as described by departmental job specifications.

c. Minimum Training Standards.

(1) Contracted and departmental case managers will receive pre-service training on the topics of training as set forth in paragraph 5-4 of this operating procedure, as well as on the following topics:

(a) Use of assessment instruments;

(b) Use of the Client Information System; and,

(c) Overview of DCF services for adults, (across all programs).

(2) Contracted providers of case management are responsible for developing and conducting the above required in-service training in accordance with the scope of training as set forth in paragraph 5-4 of this operating procedure.

d. Recommended Staffing and Caseload Standards.

(1) The average caseload should not exceed 55 cases per full-time CCDA case manager, unless approved by the district/region Adult Services Program office.

(2) A caseload consists of those clients determined eligible and receiving case management.

2-5. Chore Service.

a. Service Definition and Unit of Measure.

(1) Chore service means the performance of house or yard tasks such as seasonal cleaning, yard work, lifting and moving furniture, appliances or heavy objects, essential errands, simple household repairs which do not require a permit or specialist, pest control, and household maintenance.

(2) A unit of service is one hour of actual time spent in the performance of listed or related chore service tasks for one or more clients. If the service is to be provided to a couple, the unit of service will be assigned to either the eligible husband or wife, preferably the one who usually performs chore duties.

b. Minimum Service Standards.

(1) Chore services should be of short duration performed for a client on a demand-response basis by a contracted provider.

(2) Tasks to be accomplished will be determined by evaluating the health and well being of the client.

(3) Some chore tasks, such as errands or yard work, may be scheduled at regular intervals, if needed.

c. Minimum Training Standards. Pre-Service Training and In-Service Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-6. Emergency Alert/Response Service (EAR).

a. Service Definition and Unit of Measure.

(1) Emergency alert/response service means a community based electronic surveillance service that monitors the safety of an individual in his/her own home by means of an electronic communication link with a response center. Components of the system transmit a specially coded signal via electronic digital equipment, over existing telephone lines to a central station offering surveillance services 24 hours a day, seven days a week. Upon receipt of such signal, the central station will alert and dispatch police, fire department, ambulance, friends and/or neighbors directing emergency services to the home of the client.

(2) A unit of service is one day (24 hours) of individual emergency response unit operation in a client's residence, regardless of actual emergency use by client. The units are counted by totaling the number of days the client receives services. Example: A client who has the unit in his/her home for the entire month of June has used 30 units (30 days in June of emergency alert/response service.)

b. Minimum Eligibility Standards.

(1) It must be determined that the client is especially vulnerable to medical or other emergency situations which have a likelihood of developing, given the particular client's profile (mental, physical, social) and/or living situation.

(2) It must be determined that emergency response service could prevent such situations from developing or escalating, or could save the client from a life threatening situation.

(3) Client must have, or be willing to arrange for, any special provisions needed for installation, such as private line telephone service.

(4) Client must be mentally and physically able to use the equipment appropriately.

c. Minimum Service Standards.

(1) The EAR service provides a means of responding to an emergency situation arising in the home setting involving a disabled adult. It does not provide emergency services, but rather contacts the appropriate personnel who will provide emergency services.

(2) All equipment is to be approved by the Federal Communications Commission (FCC) and both the button and the communicator must have proper identification numbers.

(3) The emergency response Central Receiving Station equipment consists of a primary receiver, a back-up receiver, a clock printer, a back-up power supply, and a primary and back-up telephone line monitor.

(4) The EAR equipment installed in the client's home consists of a portable button which sends a wireless signal, and a communicator which receives the wireless signal and then transmits the signal to the Central Receiving Station. The communicator has a digital dialer that is designed to provide an audible and visual indication of system operation for visual and hearing impaired clients.

(5) The communicator is attached and does not interfere with normal use of the telephone. It has the capability of automatically seizing the telephone line, even if the phone is off the hook, dialing the number of the Central Receiving Station and giving identifying information about the client.

(6) Contracted providers will purchase, rent or lease the equipment that meets the above given specifications and arrange for installation, training and maintenance of the equipment.

(7) Contracted providers will designate an emergency response Central Receiving Station where emergency signals are responded to according to a specified operating protocol.

(8) Contracted providers will ensure that client, signal activity, and service records are maintained either by the provider or the response center.

(9) Contracted providers will arrange monthly phone calls to each client's home to test system operation, update records and provide direct client contact.

(10) The communicator should continually check for no-power conditions and indicate such conditions to the user. The communicator should check for an active telephone line at least once every 24 hours. If no signal is received the Central Receiving Station will contact the client to test the unit. If no test signal is received, service will be dispatched immediately.

(11) Batteries and telephone jack installation fees are costs incurred by the client, unless there is an inability to pay for these expenses. It is allowable for the project to purchase batteries and pay for installation if the client cannot pay.

d. Minimum Operational Standards.

(1) The contracted vendor will provide the contracting agency with appropriate personnel, operational and technical manuals and training.

(2) The contracted provider will make available to the department (upon request) those detailed manuals from the emergency response equipment vendor relating to operational aspects of the system including technical specifications, installation, testing and field coordination.

(3) The contracted provider will make available to the emergency response Central Receiving Station operations manuals which describe the CCDA program elements including record keeping and reporting

procedures; equipment testing; installation in subscriber's home; user agreement; and suggested reporting forms and invoices.

e. Minimum Training Standards.

(1) Pre-Service Training. Contract service providers and/or DCF staff, and emergency response Central Receiving Station personnel will receive pre-service training on location and all operational aspects of the equipment, subscriber installation, equipment testing, and program implementation. Topics and scope of training will be as set forth in paragraph 5-4 of this operating procedure.

(2) In-Service Training. In-service training for staff providing emergency alert/response service will be regularly scheduled. Topics and scope of training will be as set forth in paragraph 5-4 of this operating procedure.

2-7. Escort Service.

a. Service Definition and Unit of Measure.

(1) Escort Service means the personal accompaniment of an individual to, and/or from service providers, or personal assistance to enable clients to obtain required services needed to implement the service plan.

(2) A unit of escort service is one trip. One trip is defined as one, one-way trip measured from a point of origin to a destination.

b. Minimum Service Standards.

(1) Escort service should be provided for clients who do not have anyone in their support system to assist them, or, whose support system does not yield an individual capable (mentally or physically) of providing the assistance.

(2) The person providing the escort service may not advise the client on any matter which may constitute conflict of interest.

c. Minimum Training Standards. Pre-Service Training and In-Service Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-8. Group Activity Therapy.

a. Service Definition and Unit of Measure.

(1) Group activity therapy means a service provided to three (3) or more CCDA clients to prevent social isolation and to enhance social and interpersonal functioning. This service may include the following activities: physical, recreational, social interaction, and communication skill building through the use of groups.

(2) A unit of service is one client receiving group activity therapy for one daily session.

b. Minimum Eligibility Standards.

(1) Client must need the above described service in order to achieve a specific care plan goal which will help them to function more independently.

(2) Client must show measurable improvement in social, interpersonal, and communication skills through the provision of this service in order to continue to be eligible to receive the service.

c. Minimum Service Standards.

(1) Only a professional staff person with demonstrated abilities in group dynamics and skill in conducting the above described group activities may provide group activity therapy.

(2) Group activity therapy should provide an arena in which clients in need of service can increase their success in social interaction, communication, and interpersonal functioning.

(3) Group activity therapy is not considered a psychiatric service where medical treatment in the form of group therapy is provided.

d. Minimum Training Standards.

(1) Pre-Service Training. A total of 10 hours per year is required for contract service providers and DCF staff. The following topics, along with those listed in paragraph 5-4 of this operating procedure should be included:

(a) Group therapy and group dynamics; and,

(b) Recreational activities for the disabled client.

(2) In-Service Training. As set forth in paragraph 5-4 of this operating procedure.

2-9. Home Delivered Meals.

a. Service Definition and Unit of Measure.

(1) A home delivered meal is a hot or other appropriate, nutritionally sound meal that meets one-third of the Daily Recommended Dietary Allowances (RDA) served in the home to a disabled person who is homebound and at nutritional risk.

(2) The unit of service is one meal delivered.

b. Minimum Provider Standards.

(1) The CCDA service criteria will be met if the meals are provided by a contractor who is approved to provide home delivered meals that are funded by the Older Americans Act or by the Department of Elder Affairs' Community Care for the Elderly (CCE) Program.

(2) Each provider must serve home delivered meals at least once a day, five or more days a week.

(3) The nutrition provider must assure that each recipient of a home delivered meal:

(a) Has a home equipped with electricity, a stove with an oven that works, a working microwave oven, or a working toaster oven, and a freezer in which to store the meals.

(b) Has both the physical and mental capability (or a capable caregiver) to follow cooking directions and use the equipment.

(c) Is instructed on a regular on-going basis on the importance of following the directions for the storage and cooking of their delivered meals.

(4) Each provider must deliver the noon meal, if it is a hot meal, no earlier than 10:30 a.m. and no later than 2:30 p.m.

(5) Providers must maintain temperatures of 140 degrees Fahrenheit for hot foods being prepared and packaged at the home delivered meals site in accordance with 64E-11.004, Florida Administrative Code for purposes of food safety.

(6) To avoid potential contamination of foods delivered as pre-portioned individual meals, providers must maintain the temperature of hot food items at 110-120 degrees Fahrenheit in transit and upon delivery to the meal recipient. Providers must maintain the temperature of cold foods at 41 degrees Fahrenheit or lower. All cold and hot food must be packaged and packed separately.

(7) Providers must assure that all pre-portioned foods are delivered to clients' homes within two hours of apportionment.

(8) Providers must package or pack all meals/food items in secondary insulated food carriers, and transport it immediately under conditions that will ensure temperature control during delivery and prevent contamination and spillage.

(9) Providers must conduct quarterly temperature checks on a random basis to assure that all food at the site, packaged and in transit to be delivered, is maintained and served at the proper temperature. Both the procedure and results of these temperature checks must be documented and maintained by providers for DCF monitoring review.

(10) Providers must clearly date and label each frozen meal with instructions for storage and cooking in large print.

c. Minimum Training Standards.

(1) Pre-Service. All contract service providers and departmental staff (volunteers or paid) involved in home-delivered meals service, whether in meal preparation or delivery, must receive pre-service training. Training will be appropriate to respective job duties and be conducted as set forth in paragraph 5-4 of this operating procedure. Training must minimally provide instructions for performing assigned tasks.

(2) In-Service. In-Service Training will be conducted as set forth In paragraph 5-4 of this operating procedure, Common Service Issues.

2-10. Home Health Aide.

a. Service Definition and Unit of Measure.

(1) Home health aide service means health or medically oriented tasks furnished to an individual in his residence by a trained home health aide under the supervision of a health professional. The home health aide must be employed by a licensed home health agency and supervised by a licensed health professional who is an employee or contractor of the home health agency.

(2) The unit of service is one hour (or quarter hour portion) of time spent performing designated home health aide services. It may include time spent in transit if the aide transports the client.

(3) This is a health maintenance service to be provided in compliance with the regulation of Home Health Care in Chapter 400, F.S.

b. Minimum Eligibility Standards.

(1) In order to be eligible to receive this service, the client's medical supervision must be under an established plan of treatment. A plan of treatment means a written instruction provided by the attending physician for the provision of health care to the disabled adult in his or her own home. The plan of treatment will include:

(a) Care plan;

(b) Types of services and equipment required;

(c) Specific frequency of visits such as two times a week or three times a week for a specified length of time each visit;

(d) Activities planned or prohibited;

(e) Diet (regular or special);

(f) Listing of medications and treatments; and,

(g) Orders of the physician.

(2) This plan of treatment written by the attending physician must provide for delivery of health care services to the disabled adult in his or her own home.

c. Minimum Service Standards.

(1) The home health aide will perform only those activities contained in a written assignment by a health professional employee. Those activities include assisting the patient with personal hygiene, ambulation, eating, dressing and shaving.

(2) The home health aide may perform other activities as taught by a health professional employee for a specific patient. These include and are limited to: assisting with the change of a colostomy bag; a shampoo; or the reinforcement of a dressing; assisting with the use of devices for aid to daily living (walker, wheelchair); assisting with prescribed range of motion exercises which the home health aide and the patient have been taught by a health professional employee, assisting with prescribed ice cap or collar; doing simply urine tests for sugar, acetone or albumin; measuring and preparing special diets; measuring fluid intake and output; and supervising the self-administration of medications. This supervision means reminding clients to take medications, opening bottle caps for clients, reading the medication label to clients, observing clients while taking medications, checking the self-administered dosage against the label of the container and reassuring clients that they have obtained and are taking the correct dosage.

(3) The home health aide may not perform any personal health service that has not been included by the professional nurse in the patient's care plan. The home health aide will not at any time: change sterile dressings; irrigate body cavities, such as an enema; irrigate a colostomy or wound; perform a gastric lavage or gavage; catheterize a patient; administer medications; apply heat by any method; care for a tracheotomy tube; or administer eye drops.

(4) The home health aide must keep records of personal health care activities and the hours spent performing the tasks.

(5) The home health aide will observe appearance and gross behavior changes in the patient and report any changes to the professional nurse.

(6) A health professional staff person must evaluate the home health aide patient services in the home for the purposes of observing service delivery and the status of the client. The health professional must make a supervisory visit to the client's home at least every two weeks if the client needs skilled care and once every 62 days if the client needs only aide services.

d. Minimum Staffing Standards.

(1) The service must be provided by persons licensed under Section 400.471, F.S. or by independently licensed contractors under the supervision of a health professional.

(2) This service must be provided in compliance with Chapter 59A-8, F.A.C., Home Health Aide.

e. Minimum Treatment Plan Standards.

(1) The plan of treatment will be established and reviewed by the attending physician in consultation with agency staff involved in giving service to the patient. The reviews will be at such intervals as the severity of the patient's illness requires, but in any instance, at least every 30 days for CNA provided care or every 62 days if services provided by an LPN and shall include, but not be limited to the following:

(a) A diagnosis or identification of the disease/disability from its evident signs and symptoms.

(b) The types of remedial services to be employed as a part of the treatment plan and the equipment required to perform those services.

(c) The specific frequency and duration of the planned home health aide visits, such as two times a week or three times a week for one hour intervals each visit.

(d) Any recommended restrictions to the client's normal activities of daily living.

(e) Any recommended dietary restrictions.

(f) Attending physician's prescribed medications and medical treatments.

(g) The attending physician must date and sign the treatment plan.

(2) The case manager must make assessment of the need for home health aide services. The case manager must develop a care plan specifying frequency and duration of service, and formulated with the nurse supervisor, physician, licensed physical therapist, or licensed occupational therapist prior to the delivery of service.

(3) A registered nurse, either paid or volunteer, must be on staff or under contract as a consultant to make home visits to each client. The registered nurse will supervise the home health aides, assess whether the service plan is being carried out properly, attend or provide in-service training, review reports and records, and assist in employee performance evaluations.

(4) The home health aide records services rendered during each visit, completes time and attendance records, participates in performance evaluations, prepares incident reports as the need arises, and attends pre-service and in-service training.

(5) Home health aide care will not substitute for care provided by a registered or practical nurse, or a licensed therapist.

f. Minimum Training Standards.

(1) Pre-Service Training. The home health aide must have training in supportive services, which are required to provide and maintain bodily and emotional comfort, and assist the patient toward independent living in a safe environment. If the aide receives training through a vocational school, licensed/certified home health agency, or hospital, the curriculum will be documented. If training is received through the agency, the curriculum will consist of at least 42 hours that include:

(a) Role of the home health aide, differences in families, ethics, and orientation to the agency (2 hours).

(b) Physical appearance and personal hygiene (1 hour). The following topics should be included: uniform; hair; hands and fingernails; cleanliness; teeth; makeup; perfume; jewelry and smoking.

(c) Supervision by a registered nurse registered physical therapist, occupational therapist, registered speech therapist (3 hours). The following topics should be included: role of the supervisor; role of the aide; role of the physician; role of the patient; plan of care; assignment of tasks; record keeping; and performance evaluation.

(d) Personal care services (24 hours), to include the following topics: bathing; dressing; toileting; feeding (eating); bed making; ambulation; body mechanics; transfer techniques; range of motion and exercises.

(e) Nutrition and food management (4 hours), to include the following topics: basic food requirements; purchasing of food; preparation of food; storage of food; serving of food; and special diets.

(f) Household management (2 hours), to include the following topics: care of bedroom, bathroom, kitchen; care of clothing; and safety in the home.

Emotional aspects of disability, including death and dying (6 hours).

(2) In-Service Training. In-service training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-11. Homemaker Service.

a. Service Definition and Unit of Measure.

(1) Homemaker service means the performance of or assistance in accomplishing specific home management duties including housekeeping, laundry, meal planning and preparation, shopping assistance, and routine household activities by a trained homemaker. With district/region approval, it may include the purchase of home and/or cleaning supplies needed for the delivery of services. Otherwise, clients are responsible for purchasing their own cleaning supplies.

(2) The unit of service is one hour (or quarter hour portion) of time spent in the provision of designated homemaker duties by a trained homemaker. It does not include time in transit to and from the client's place of residence except when providing shopping assistance, performing errands or other tasks on behalf of the client. If the service is to be provided to a couple, the unit of service must be assigned to either the eligible husband or wife, preferably the one who usually performs homemaking duties.

b. Minimum Service Standards.

(1) The homemaker may plan and prepare meals according to the client's dietary needs.

(2) The homemaker may perform light housekeeping.

(3) The homemaker may wash and dry dirty laundry at the client's expense, either at the client's home or at a Laundromat.

(4) The homemaker may repair the client's clothing at the request of the client.

(5) The homemaker may perform minor home maintenance (i.e. changing light bulbs).

(6) The homemaker may assist the client with shopping or shop for the client.

(7) The homemaker may assist the client with budgeting and paying bills.

(8) The homemaker may transport the client in the agency vehicle only with prior authorization by supervisor or case manager.

(9) The homemaker is responsible for all record keeping as required by the contracted agency.

(10) The homemaker is responsible for reporting changes in client condition or behavior to the supervisor.

(11) The homemaker is responsible for following established emergency procedures.

c Restrictions on Service Standards.

(1) The homemaker must not engage in work that is not specified in the homemaker assignment.

(2) The homemaker must not accept gifts from clients.

(3) The homemaker must not lend or borrow money or articles from clients.

(4) The homemaker must not perform services requiring a public health nurse, a home health aide, or personal care worker to perform.

(5) The homemaker must not handle money unless authorized by the supervisor or the case manager and bonded or insured by the employer.

(6) The homemaker must not transport the client unless authorized by the supervisor or case manager.

d Minimum Service Provision Log Standards.

(1) The homemaker is required to fill out a client service provision log.

(2) Any form used must record the following: the date of the visit; activities performed during the visit, and number of hours spent performing the activities.

e Minimum Training Standards.

(1) Pre-Service Training. A total of 20 hours are required covering the following: CCDA program and purpose; medical and psychological aspects of disability; interpersonal relationships; nutrition and meal preparation; marketing and food storage; use of household equipment and supplies; planning and organizing household tasks; principles of cleanliness and safety of the home; record-keeping; agency policies and procedures; and emergency procedures.

(2) In-Service Training. In-Service Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-12. Home Nursing Services.

a. Service Definition and Unit of Measure.

(1) Home nursing service means a part-time or intermittent nursing care administered to a client by a licensed professional or practical nurse or advanced registered nurse practitioner, as defined in Chapter 464, Florida Statutes. This service must be delivered in the place of residence used as the client's home, pursuant to a plan of care approved by a licensed physician.

(2) The unit of service is one hour of client contact by the registered nurse, advanced registered nurse practitioner or the licensed practical nurse.

(3) This is a health maintenance service which includes those routine health service(s) necessary to help maintain the health of a disabled adult.

b. Minimum Eligibility Standards.

(1) A physician's prescription/plan of treatment is required to obtain home nursing services.

(2) A request for continuation of services, signed by a physician, is required at sixty-two (62) day intervals.

(3) Funding sources inclusive of, but not limited to, Medicare, Medicaid and third party payment must be exhausted prior to utilization of CCDA funding for provision of home nursing services.

c. Minimum Service Standards.

(1) Home nursing provides services that assist the client in his/her efforts to maintain an optimal level of health of body and mind. These services are to prevent the occurrence or progression of illness, thus decreasing the number of hospitalizations.

(2) Home nursing can be rendered through a home health agency, or provided by an independently practicing registered nurse, a registered nurse employed by a county health unit, or an independently practicing licensed practical nurse working under the direction of a registered nurse.

(3) Nursing services rendered in the home shall include observation, assessment, nursing diagnosis, care, health teaching and counseling, maintenance of health, prevention of illness, administration of

medically prescribed medications and treatments, and the supervision and teaching of others in the performance of nursing tasks.

(4) Home nursing service will not be rendered in hospitals or skilled or intermediate care facilities.

d. Minimum Staffing Standards.

(1) A provider of home nursing services must hold a current license under Chapter 464, F.S.

(2) The home nursing provider must be operating within their scope of practice, and pursuant to the client's physician's plan of treatment.

e. Minimum Training Standards. Pre-Service Training and In-Service Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-13. Interpreter Service.

a. Service Definition and Unit of Measure.

(1) Interpreter service means assisting a client to communicate despite a hearing or speech impairment or language barrier. Deaf individuals with multiple physical disabilities are even more challenged in regards to their receptive and transmittal skills. They may require special communication efforts in sign language, oral/aural interpreters, voice interpreters, tactile interpreters or cued speech interpreters.

(2) A unit of interpreter service is one hour spent in providing interpreter service to and/or for a client.

b. Minimum Eligibility Standards.

(1) Client must have a communication barrier significant enough to prevent him/her from effectively and accurately receiving or giving information.

(2) Client must not be able to secure the service from his or her own support system.

c. Minimum Service Standards.

(1) Interpreter service is to be used to free clients from significant barriers to communication. Barriers: language and deafness.

(2) Interpreter service should be used to assist clients to access community resources, medical services, or social security, disability, or other governmental agency resources.

(3) All organizational units within the department of Children and Families must adhere to the department's operating procedures, CFOP 220-5, Providing Interpreting Services For People Who Are Deaf or Hard of Hearing, when procuring these services for DCF clients.

d. Minimum Staffing Standards.

(1) Sign language interpreters are expected to abide by the Code of Ethics which appears in "Interpreting for Deaf People" (a Department of Health and Human Services publication). This code presents standards of ethical practice including an emphasis on confidentiality, impartiality, non-paternalism, and the continual development of skill.

(2) Language interpreters must possess valid certification as established by the national Registry of Interpreters for the Deaf (RID), the National Association for the Deaf (NAD), and/or have been determined qualified to interpret by the Florida Registry of Interpreters for the Deaf, Inc. (FRID) through the "Quality Assurance (QA) Screening Program". By using RID or NAD certified or QA Screened interpreters in the appropriate circumstances, we protect consumer as well as departmental interests.

e. Minimum Training Standards. Pre-Service Training and In-Service Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-14. Medical Equipment and Supplies.

a. Service Definition and Unit of Measure.

(1) The purchase of medical equipment and supplies for use by CCDA clients is allowable under the CCDA program. Medical equipment and supplies may be durable, such as walkers, wheelchairs, bedside commodes, etc., or it may be non-durable, such as bed pads, colostomy supplies, adult diapers, etc.

(2) There is no measurable "unit" of service for this category. Instead, providers are requested to maintain documentation regarding the expenditure of CCDA funds for this service. The following information should be tracked:

(a) Description of the kinds of equipment requested and needed, and how many requests were received for each (annually);

(b) Of the requests documented, how many received the needed equipment (annually);

(c) Itemization of durable equipment purchased: description, quantity, and price per item (annually);

(d) Number of clients utilizing each type of durable equipment purchased (annually);

(e) Itemization of non-durable equipment purchased: description, quantity, and price per item (annually); and,

(f) Number of times non-durable equipment/ supplies was given to CCDA clients.

b. Minimum Service Standards.

(1) The purchase of medical equipment and supplies should be used only as the last resource to provide the client with needed items.

(2) The purchase of medical equipment and supplies can include both durable and non-durable equipment. Case managers will explain to the clients that the durable equipment being loaned to clients is for their use only so long as they remain an active client in the program and their care plan deems the equipment necessary to their every day functioning.

c. Minimum Service Restrictions.

(1) Durable equipment should be loaned and returned to the program when the client no longer needs it, so that others may use it.

(2) Non-durable equipment/supplies are not to be reused.

(3) Expenditures of more than $100.00 are to be approved by the district/region before purchase.

(4) Case managers may request verification from the client's physician for the necessity of any particular item or service.

(5) Supplies need to be related to the client's medical condition.

d. Minimum Training Standards. There are no Pre-Service or In-Service Training standards for delivery of this service.

2-15. Medical Therapeutic Services.

a. Service Definition and Unit of Measure.

(1) Medical Therapeutic Services means corrective or rehabilitative services which are prescribed by a physician or other appropriate health care professional licensed in the State of Florida, designed to assist the disabled person to maintain or regain sufficient functional skills to live independently in the least restrictive environment possible.

(2) Such therapies are necessary services for individuals who have suffered physical damage or debilitation due to disease, trauma or premature aging and may include occupational therapy, physical therapy, respiratory therapy, and services for individuals with speech, hearing and language disorders.

(3) The unit of service is one hour of client contact by the health professional in the client's place of residence or facility where the service can be provided (e.g., hospital outpatient rehab center.).

(4) This is a health maintenance service as defined by its respective practice acts in Chapter 486, F.S.

b. Minimum Eligibility Standards.

(1) A physician or nurse practitioner, or speech, occupational, or physical therapist, must prescribe the needed services.

(2) A request for continuation of services, signed by one of the professionals named above is required at every sixty-two (62) day intervals.

(3) A client receiving like services under another program component will not be regarded as eligible for duplicative medical therapeutic services. For example, a recipient of physical and occupational therapy while in an adult day care program will not be eligible for duplicative services in his/her place of residence or at a provider facility, unless the frequency of treatment(s) required does not correspond with the frequency of attendance at day care.

c. Minimum Service Standards.

(1) Services shall include occupational therapy, physical therapy, speech pathology and audiology. Definitions for these therapies may be found in the glossary.

(2) Payment for supplies and equipment deemed by the therapist or physician as reasonable and necessary to the success of the treatment rendered to the client, will be eligible under this program in accordance with project budgets. All resources will be exhausted prior to the utilization of CCDA funds for the purchase of supplies or equipment for medical therapeutic services. THE CCDA PROGRAM SHALL BE THE PROVIDER OF LAST RESORT.

d. Minimum Education and Training Standards.

(1) Any provider of a medical therapeutic service must hold current license to practice in the State of Florida in the designated area of the services to be provided, and according to the prescription of a physician. The physician prescription must be renewed every 62 days.

(2) Pre-Service Training. None is required.

(3) In-Service Training. In-service training requirements can be met through attendance at professional meetings/conferences and/or required course work for continuation of registration, certification or licensure status. A minimum of six hours of meeting attendance, course work or other training related to the job function must be obtained per year; content and duration must be documented in staff and agency records holding documentation of the employee's professional qualifications.

2-16. Personal Care.

a. Service Definition and Unit of Measure.

(1) Personal care means services to assist the disabled adult with bathing, dressing, ambulating, housekeeping, supervision, emotional security, eating, supervision of self-administered medications and assistance with securing health care from appropriate sources. Personal care services do not include medical services.

(2) A unit of service is one hour (or quarter hour) of elapsed time spent in providing designated personal care services by a qualified personal care aide.

b. Minimum Staffing Standards.

(1) Personal care aides must be employed by a Lead Agency, a licensed home health agency under contract with the department or by an independent contractor under the supervision of a health professional.

(2) A registered nurse, either paid or volunteer, must be on the staff or under contract with the contracted personal care agency to make home visits to supervise personal care aides at least every 90 days.

(3) The registered nurse will assess whether activities in the service plan are being carried out properly; attend or provide in-service training; review reports and records; and conduct or participate in meetings to staff clients. All such activities shall be documented in the case record.

(4) The registered nurse must also participate in the performance evaluation of the personal care aide.

c. Minimum Service Standards.

(1) The personal care aide will assist the client with personal hygiene, dressing, feeding, transfer and ambulatory needs, including use of a wheelchair, crutches, or walker when applicable.

(2) The personal care aide will assist the client with toileting and/or use of a bedpan.

(3) The personal care aide will assist the client with self-administration of medications when ordered by the client's physician, and as prescribed in the personal care plan. The personal care aide may not administer the medication, but may bring the medication to the client and remind the client to take the medication at a specific time;

(4) The personal care aide will assist the client with food, nutrition and diet activities including preparation of meals when essential to good health;

(5) The personal care aide will assist the client performing household services such as changing bed linens, when the performance is essential to good health;

(6) The personal care aide will accompany the client to clinics, physician office visits, or other trips, when health care needs require personal care assistance.

d. Minimum Service Restrictions.

(1) Personal care will not substitute for the care usually provided by a registered or practical nurse, therapist, or home health aide. The personal care aide WILL NOT change sterile dressings, irrigate body cavities, irrigate a colostomy or wound, perform gastric irrigation or enthrall feeding, catheterize a client, apply heat by any method, care for a tracheotomy tube, administer medications, or provide any personal health service which has not been included in the patient care plan as prohibited by rules and regulations.

(2) Personal care services MUST NOT be confused with services that are commonly associated with homemaker and home health aide services. Services must be required SPECIFICALLY TO ASSIST THE CLIENT as outlined in the above sections.

e. Minimum Training Standards.

(1) Personal care aides must be trained in those supportive services that are required to make the client comfortable and to assist the client toward independent living in a safe environment.

(2) Pre-Service Training. The personal care staff will receive a minimum of thirty class hours of pre-service training. This training will include:

(a) Ethics and the role of the personal care provider (one hour).

(b) Physical appearance and personal hygiene (one hour).

(c) Supervision by registered nurse (three hours). This should include topics such as: role of the supervisor; role of the personal care aide; role of the physician; role of the client; plan of care; assignment of tasks; record-keeping and employee performance evaluation.

(d) Personal care services (eighteen hours), to include the following topics: bathing; dressing; toileting; feeding (eating); bed-making; ambulation; and body mechanics.

(e) Nutrition and food management (four hours), to include the following topics; purchasing food; preparation of food; storage of food; and serving of food.

(f) Household management (two hours), to include: care of bedroom, bathroom, kitchen; care of clothing and safety in the home.

(g) Physical, mental, and social aspects of disability; and the social aspects of death and dying (two hours).

(3) In-Service Training. In-Service Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

2-17. Physical and/or Mental Examinations.

a. Service Definition and Unit of Measure.

(1) CCDA funds may be used to purchase the services of a physician or psychologist/psychiatrist/mental health professional in order for a CCDA client to receive needed medical or mental health services for the purpose of evaluation. Physical and mental examinations should not be provided for extensive treatment or treatment needed over time through numerous examinations. THE DPOAA MUST APPROVE EACH EXAMINATION BEFORE SERVICES ARE RENDERED.

(2) A unit of service is measured in episodes, with one episode (one unit) defined as one examination, either physical or mental, made by one physician, psychologist, or mental health professional (see glossary for definition).

(3) This is a health maintenance service as defined by Section 410.603(4), F.S., it is those routine health service(s) necessary to help maintain the health of the disabled adult.

b. Minimum Training Standards.

(1) Pre-Service Training. A provider of physical or mental examinations must hold a license in good standing to practice medicine, or to conduct psychological examinations, or in the case of professional mental health counseling, must be certified as a mental health professional.

(2) In-Service Training. There are no in-service training requirements.

2-18. Respite Care.

a. Service Definition and Unit of Measure.

(1) Respite care means relief or rest for a primary caregiver from the constant supervision, companionship, therapeutic and personal care on behalf of the client for a specified period of time. The purpose of the service is to maintain the quality of care to the client for a sustained period of time through temporary, intermittent relief of the primary caregiver.

(2) The unit of service is one hour or quarter hour of elapsed time spent in the provision of respite care services by a qualified worker.

b. Minimum Service Standards.

(1) Respite care may be provided for up to 240 hours per client per calendar year depending upon individual need. The service may be extended up to 360 hours as recommended by the client's case manager and with documented approval by their immediate supervisor. The service may be provided during a concentrated period or spaced throughout the year. The district/region may approve additional hours on a case by case basis.

(2) The case manager will determine the level and intensity of care required by a client. The case manager may obtain consultation from other service providers, the client's family, caregiver, physician, or nurse to determine the appropriate level of respite care needed.

(3) **Respite care will not be substituted for the care usually provided by a registered nurse, licensed practical nurse, or therapist.**

(4) In-home respite care may be provided by staff qualified as a homemaker, home health aide, personal care worker, sitter or companion, a combination of the above, or a trained volunteer, as long as service standards are met.

(5) Services provided for respite purposes will be classified as such and not as homemaker, home health aide, personal care services and the like, even though a homemaker or health aide may render the service.

(6) Respite care staff must be appropriately supervised. A health or social service professional must be available to supervise and provide in-service training to workers providing the respite services. If, for medical reasons, a home health aide must provide all or parts of the respite care services, a registered nurse or health professional must supervise the aide. As an alternative, an agreement may be developed with a visiting nurses association, the Red Cross, or a home health agency, to supervise respite staff.

(7) Respite care is to be provided in the CCDA client's home in familiar surroundings, however, when a respite caregiver is not available to go to the client's home, respite care may be provided in an adult day care facility, adult living facilities, or nursing home on a temporary basis. RESPITE CARE SERVICE MAY NOT BE PROVIDED TO RESIDENTS OF NURSING HOMES OR ASSISTED LIVING FACILITIES.

c. Minimum Education and Training Standards.

(1) Pre-Service Training. Staff or volunteers providing this service must receive at least twenty hours of instruction in the following areas:

(a) Health problems and care of disabled persons.

(b) Basic personal care procedures such as grooming.

(c) First aid and handling of emergencies. Formal written emergency procedures will be developed for the respite staff to follow should an emergency occur.

(d) Food, nutrition, meal preparation, and household management.

(2) In-Service Training. Training required is dependent upon level of care provided. If personal care is to be provided, the personal care standards must be met.

(3) Education required is dependent upon level of care provided; however, the respite worker must have the ability to read, write, and complete required reports.

2-19. Transportation.

a. Service Definition and Unit of Measure.

(1) Transportation service means the transport of a client to and/or from service providers or community resources. Any transportation essential to the implementation of the service plan is allowable. CCDA funds may not be used to purchase transportation vehicles.

(2) Transportation service is measured in trips: one trip is defined as one, one-way trip measured from a point of origin to a destination. The following are examples of measurement:

EXAMPLE: Client is taken from home to the doctor's office (1 trip). Client is then taken from the doctor's office to the drug store (1 trip). Client is returned from the drug store back home (1 trip). Total number of trips this episode is 3 trips.

EXAMPLE: Client is taken from home to rehab therapy.(1 trip)
Client is taken from rehab therapy to the grocery store.(1 trip) Client is then taken from the grocery store to the drug store.(1 trip) Client is taken from the drug store back to the grocery store (forgot eggs).(1 trip) Client is returned from the grocery store back home.(1 trip) Total number of trips this episode is 5 trips.

b. Minimum Standards for Service Delivery.

(1) Services will be provided on a demand/response basis. Except for emergencies, clients must request services at least 24 hours in advance to facilitate efficient use of vehicles and staff.

(2) Existing transportation systems and equipment must be utilized before CCDA funds are used for transportation services.

(3) An ambulance, taxicab, common carrier, or project vehicle may provide services. The agency or the vehicle owner must provide excess liability coverage. Transportation services will be provided only by persons having a valid Florida driver's license. If volunteers are used, they must have a valid driver's license. Drivers who transport clients on a regular basis in project vehicles must have a valid Florida Chauffeur's license.

(4) When transporting one or two clients, a driver may act as an escort provided that the case manager determines that the client cannot be left alone while receiving the services, and the client's needs will not interfere with the driver's ability to safely control the vehicle. In such instances, only one or the other may be counted in units of service, transportation trips or escort hours.

(5) If the need to supervise a client will interfere with a driver's ability to safely transport, the provider will send another qualified staff person along to provide supervision of that client.

c. Minimum Provider Service Standards.

(1) Must be in compliance with federal, state and local regulations as well as those regulations issued by the Department.

(2) Transportation providers must document that staff personnel and volunteers are fully trained to provide the services offered by the transportation program.

(3) Transportation providers must obtain and maintain minimum vehicle insurance coverage on all provider owned or leased vehicles in accordance with the Division of Risk Management.

(4) Transportation providers must document that all drivers who transport clients on a regular basis in provider vehicles have:

(a) A valid State of Florida Chauffeur License.

(b) Minimum of one year driving experience with vehicles similar to those to be operated for the project.

(c) A safe driving record acceptable for insurance coverage.

(d) Successfully completed an American Red Cross or similar program to meet health emergencies and accidental injuries.

(e) Document that volunteers who drive privately owned automobiles to transport clients meet standards as set forth in CFOP 125-1, Community Resources/Volunteer Management.

(f) Report all unusual incidents, accidents or problems to proper authorities to be investigated and to employee's supervisor to be recorded on provider files.

d. Minimum Training Standards.

(1) Pre-Services Training. A total of ten hours is required for contract service providers and DCF staff. The following topics should be included in the training: interpersonal relationships; operation of vehicle and equipment; and accident and emergency procedures in the event something may happen to the client while being transported. Training will be conducted as set forth in paragraph 5-4 of this operating procedure.

(2) In-Service Training. Contract service staff providing medical transportation must be scheduled regularly for in-service training to augment or refresh knowledge in any of the above listed areas. In-Service training will be conducted as set forth in paragraph 5-4 of this operating procedure.

Chapter 3
FEE ASSESSMENT PROCEDURES

3-1. Purpose. The purpose of this chapter is to explain in simple terms the schedule of fees for services to be charged to the disabled adult whose income exceeds the Institutional Care Program (ICP) limit. The assessed fee amounts will be collected based on the disabled adult's ability to pay.

3-2. Statutory Authority. The statutory authority for this fee is established in 410.606(6) Florida Statutes (F.S.), and the schedule of fees is defined in 65C-2.007, Florida Administrative Code (F.A.C.), Fee for Services:

a. 410.606(6) FS., reads: "The department and providers shall charge fees for services that the department provides a disabled adult whose income is above the existing institutional care program eligibility standard, either directly or through its agencies or contractors. Services of a specified value may be accepted in lieu of a monetary contribution."

b. 65C-2.007, F.A.C., reads: "Priority for services is based on need for services combined with the income level of the prospective client. First, eligibility must be determined through the administration of a functional assessment and verification of the client's income. If the income is above the existing institutional care program eligibility standard then a fee for services will be assessed. Once an applicant is deemed eligible and a priority candidate for services, a determination shall be made as to a dollar amount that the applicant will be charged for those services based on an overall ability to pay. Partial payments may also be assessed."

3-3. Why Assess for Fees.

a. The concept of fee assessment is to help increase the number of clients to be reached by the CCDA program. Fee collection permits applicants who would otherwise not meet a stringent income eligibility criteria to participate in the program.

b. It also allows expansion of the program through the increased funding base created by the client fees being remitted back into the program.

3-4. Procedures for Determining Fees To Be Assessed.

a. The case manager shall request information from the applicant or his spouse, relative or guardian if needed, as follows:

(1) Monthly income to include all earnings, payments and pensions to the applicant. Assets are not included.

(2) Expenses to include housing and utilities, telephone, food, medical expenses, transportation and insurance.

b. Necessary monthly expenses shall be subtracted from monthly income as defined in to determine the applicant's disposable income and overall ability to pay.

c. Applicants who have $200.00 or more remaining after expenses have been subtracted shall be assessed a fee toward the cost of service received.

d. The applicant will be asked to pay 10 percent of his disposable income or the unit cost of the service he is to receive, whichever is less. The unit cost will be determined from the most recent unit cost report of the provider or the fixed rate charged in a contract.

e. At the time the ability to pay is determined, the applicant shall attest to the truthfulness of his financial status by signing a written statement.

f. Redetermination of a client's ability to pay shall be on an annual basis. The client may request redetermination based upon a change of financial status.

g. The fee formula is attached (appendix A to this operating procedure). Central Office does not collect this data. Fees are district/region specifically tracked and managed as are their budgets.

3-5. Exceptions to Fee Assessment Application.

a. In those situations where the applicant is currently receiving a service on a private pay basis and can continue to pay for the service, he shall not receive the service under state Community Care for Disabled Adult funds.

b. If the service is available on a private pay basis from another agency and the client assessment has determined that the applicant can pay for the service, then the applicant shall be referred to the other agency for the services.

c. However, if the applicant is able to pay for a service, but the service is not available from any other agency, and he is in need of the service, then the Community Care for Disabled Adults provider shall provide the service, inform the applicant of the dollar amount or in-kind service, and require such fee toward the cost of the service.

d. If the client is unwilling to pay the assessed fee or contribute the in-kind services of specific value, services shall be denied.

3-6. Handling Collected Fees.

a. Fees collected must be remitted back into the CCDA program.

b. All state and provider staff directly handling assessed monies must be bonded under a group fidelity bond in individual amounts of $25,000 and insured. Bonding is to insure that every person, who has access to or control over funds collected through the program, is covered by a bond against loss resulting from employee dishonesty.

c. Each Project Director must be individually bonded for $100,000. The cost of the bonding shall be borne by the provider agency.

d. Clients shall have the opportunity to perform volunteer services in lieu of making payments, in accordance with departmental procedures.

e. Client payments shall be directed to the provider agency and may be used to expand the Community Care for Disabled Adults program.

Chapter 4
CLIENT ELIGIBILITY

4-1. Purpose. The purpose of this chapter is to set criteria to be used by case management staff for determining applicant eligibility for Community Care for Disabled Adults (CCDA) Program services.

4-2. Appropriateness of Referral. The case manager should use a screening process to determine whether the applicant has been appropriately referred to CCDA. To be eligible for CCDA services, the applicant must:

a. Be 18 through 59 years of age; and,

b. Have one or more permanent physical or mental limitations that restrict the ability to perform normal activities of daily living (ADL) (see glossary definition) as determined through the initial functional assessment and documentation of disability.

4-3. Documentation of Disability. In order to receive CCDA services the case manager must establish that the prospective client is in fact disabled. Disability can be verified in one of the following ways:

a. If the applicant receives Supplemental Security Income (SSI), Social Security Disability Income (SSDI), or some other disability payment, then disability has already been established. To confirm this, the CCDA case manager must see a check, awards letter, or other evidence that indicates that the applicant is disabled. The case manager must document this verification in the case file.

b. If the applicant is not receiving a disability payment, the case manager must obtain confirmation of disability and place documentation of the same in the case file. The documentation must be in the form of a written statement from a licensed physician (Medical Doctor or Doctor of Osteopathic Medicine), licensed nurse practitioner, or mental health professional (See glossary definition). The statement must include the applicant's diagnosis, prognosis and the client's level of functioning and need for assistance due to the disability. Either the client or the case manager can obtain the statement. Once the case manager has established disability, the case manager must complete the Adult Services Client Assessment Form.

4-4. Prioritization of Clients.

a. Florida Statute 410.604 states that services are to be prioritized to applicants who are not receiving comparable services from other agencies, such as the Division of Vocational Rehabilitation and the Division of Blind Services Programs of the Department of Education, or the Brain and Spinal Cord Injury Program of the Department of Health. As program vacancies occur, the case manager will search the waiting list for the highest assessment score to fill that vacancy. When there are two or more clients who have the same score and the program does not have the means to serve both clients, the case manager must prioritize the clients for service. The case manager will consider the earliest intake date and the following items as part of the prioritization process for filling the program vacancy:

(1) The applicant is a victim of a report of abuse, neglect, or exploitation that has findings of verified or some indicators;

(2) The applicant's income is at or below the prevailing Institutional Care Program (ICP) eligibility standard;

(3) The applicant's risk of placement in an institution;

(4) The applicant's projected annualized cost of care;

(5) The services can be accessed through another means such as Medicaid, Medicare, or private payment;

(6) The applicant's informal support network; and,

(7) The geographic availability of resources within the applicant's community.

b. IF A CLIENT HAS BEEN INDENTIFIED BY ADULT SERVICES AS HAVING INDICATORS OF ABUSE, NEGLECT, OR EXPLOITATION AND IS "AT RISK", THEN SUCH A CLIENT MUST RECEIVE THE HIGHEST PRIORITY FOR SERVICES.

Chapter 5
COMMON SERVICE REQUIREMENTS

5-1. Purpose. The purpose of this chapter is to identify and address requirements common to all Community Care for Disabled Adults (CCDA) services described in chapter 2 of this operating procedure.

5-2. Common Requirements. The following is a list of the requirements that are common to all services:

a. All client information is confidential and will only be disclosed with the written consent of the client or guardian. Procedures must be established to protect confidentiality of records and to obtain the individual's informed consent prior to release of confidential information.

b. Persons and/or agencies providing services will:

(1) Develop training curriculums for pre-service and in-service training as required by operating procedure policy.

(2) Meet all statutory licensing and certification requirements.

(3) Complete a level I background screening on all employees in an employment position that allows direct service contact with any client receiving services through the Adult Services program. The screening will include employment history checks and statewide criminal correspondence checks through the Florida Department of Law Enforcement, and may include local criminal record checks through local law enforcement agencies.

(4) Comply with continuing education requirements.

(5) Obtain any required state or local permit.

(6) Meet building codes and standards.

(7) Obtain any required insurance.

(8) Deliver services only to clients living in a private residence.

5-3. Personnel Requirements. Contracted and departmental direct service personnel (inclusive of case managers) will comply with certain requirements.

a. Paid and Volunteer Staff. All staff in direct contact with clients will:

(1) Only handle the client's money if required by the service provided;

(2) Not disclose confidential information; and,

(3) Not accept monetary or tangible gifts from clients.

b. Volunteer Staff. Providers will incorporate volunteers and other community resources whenever possible and assure that services are delivered efficiently by coordinating with other agencies to obtain appropriate services.

5-4. Training Requirements. Providers will establish procedures to recruit, train, schedule, and evaluate both paid and volunteer staff and the completion of each of these procedures by individual staff will be documented in provider or personnel records.

a. Pre-service Training. Paid staff and volunteers who have direct contact with clients will participate in a basic orientation called pre-service training before providing services on a regular basis and within 6 weeks of hire. This training will consist of a minimum of 6 hours training covering the following topics:

(1) Overview of prevalent disabilities served by the Community Care for Disabled Adults (CCDA) program and the medical and psychological aspects of those disabilities;

(2) Overview of the CCDA program, its purpose, philosophy, policies and procedures;

(3) Overview of the Adult Services Network;

(4) Interviewing techniques to be used with disabled adults;

(5) Abuse, neglect, exploitation and incident reporting;

(6) Local agency procedures and protocols;

(7) Client confidentiality;

(8) Safety and home accident prevention;

(9) Emergency procedures to follow in the event of a crisis during the course of service delivery; and,

(10) The use of assessment instruments, development of care plans, and record-keeping procedures.

b. In-service Training. Unless stated otherwise in Chapter 2 of this operating procedure, both provider and district/region office staff will update their respective training curriculums and provide in-service training annually to their direct service staff.

(1) Providers will update their training curriculums and provide a minimum of three hours in-service training annually for provider staff.

(a) When providers are enrolled by District/Region Office staff, the District/Region Office will assure that providers' training curriculums are updated and annual training is provided.

(b) When providers are enrolled by another agency, that agency will assure that providers are appropriately licensed and trained.

(c) District/Region Office staff will update training curriculums and provide a minimum of three hours in-service training annually for adult Services staff.

(2) A qualified person will provide all training.

(3) The district/region may negotiate the required training methods and training materials within the provider contract or the district/region may allow the required training methods and training materials to be determined by the provider. All training curriculums must meet Office of the Secretary, Education and Training (OSET) guidelines and include the disability issue criteria established in chapter 5 of this operating procedure.

5-5. Service Restrictions. The following restrictions are applicable to service delivery and billing of approved CCDA services:

a. Travel time to and from the client's home, except for case management, is not counted in units of service unless travel time is specifically included as part of the service as documented in chapter 2 of this operating procedure; and,

b. All sources of federal, state or insurance funds (excluding local match) external to CCDA program funds must be exhausted prior to spending CCDA state general revenue funds for any approved CCDA service.

Chapter 6
ROLE OF THE COMMUNITY CARE FOR DISABLED ADULTS CASE MANAGER

6-1 Purpose. The purpose of this chapter is to clarify the role of the case manager in arranging and coordinating in home and community services to eligible clients. These guidelines provide the case manager with the needed knowledge and skills to efficiently perform client-level intervention and system-level intervention case management tasks.

a. The primary goal of a case manager is to optimize client functioning by providing a client centered series of activities involving planning, and the arrangement for and coordination of appropriate community-based services for an eligible Community Care for Disabled Adult (CCDA) client. Client-level case management includes:

(1) Intake and referral;

(2) Comprehensive uniform assessment;

(3) Development of a care plan;

(4) Arrangement and coordination of client services; and,

(5) On-going monitoring of the client's progress to assure the effective delivery of services.

b. The secondary goal of the case manager is to explore and enhance departmental relations with existing and prospective service providers to improve the client service delivery system. System-level case management includes:

(1) Analysis of the strengths and limitations of the provider network;

(2) Defining how the agency and the provider network systems can both work together to positively affect clients and strive to optimize this positive working inter-relationship;

(3) Selecting strategies to improve the district/region service delivery system; and,

(4) Assessing the effectiveness of those strategies and continuing to repeat and revise steps 1 through 3.

c. When case management is the only service a prospective client needs, then it is appropriate that it be provided by CCDA, as long as the use of CCDA funds for this purpose is the last resort for obtaining the service. It must be determined that the referral needs only case management services, and not guardianship services. Employees holding positions funded partially or wholly by the CCDA program (this includes service contract providers and DCF staff) are prohibited from serving as a client's guardian.

d. The case manager must ensure that each client receives appropriate assistance by providing accurate and complete information about the extent and nature of available services and by helping the client decide which services will best meet his or her needs.

e. The case manager must make every effort to foster and respect maximum client self-determination and ensure the client's right to privacy.

f. CCDA case management includes tracking service expenditures and insuring that the total cost, estimated or actual, for each individual receiving Community Care for Disabled Adult services is be kept below the average general revenue portion of a Medicaid nursing home bed within the district/region area. This amount will vary district by district.

6-2. Goals of CCDA Case Management. Contracted and departmental case managers are an important link between our disabled adult clients, contracted providers and the community services the clients need. Some specific goals of a CCDA case manager are listed below.

a. Accelerate the client's access to a continuum of care extending from arrangement of in-home services to institutional placement by providing clients with a single entry point into the community care service system.

b. Link disabled adults with natural supports and services in the community.

c. Monitor the physical and mental well being of clients.

d. Ensure a maximum range of service options that reflect clients' preferences in terms of providers, where services are provided, hours of services, and ways in which services are provided.

e. Prevent unnecessary duplication of services to the CCDA client by other county and state agencies.

f. Ensure the changing needs of clients are addressed to avoid or reduce unnecessary dependence upon a service that becomes inappropriate, as the client's needs change.

g. Encourage client independence and self-sufficiency.

h. Acknowledge client feedback and document gaps in the service delivery system to provide information for program planning and budgeting.

i. Nurture departmental and provider relationships and provide support to the provider and the client in order to foster a productive partnership between the two.

6-3. Basic Client-Level Functions and Responsibilities of the CCDA Case Manager.

a. Identifies Community Resources. The CCDA case manager has the responsibility for knowledge of federal, state and community resources in order to coordinate the best service package for eligible clients.

b. Receives Referrals. A separate intake worker or the CCDA case manager may receive and screen referrals. The Intake form (CF-AA 1022 or DOEA Form 111A) is used for each client referred. A separate Telephone Screening form (DOEA Form 111D) may be used in areas with a high volume of calls, to determine the prioritization of clients receiving an in-home Adult Services Client Assessment, form CF-AA 3019. The intake worker or CCDA case manager will determine whether further action is needed, or whether the applicant should be referred to another agency. If the intake or screening indicates that further action is needed, the CCDA case manager must, within three working days of the receipt of the referral, make a contact with the applicant to schedule a home visit and face-to-face assessment of the client's situation. The home visit must be conducted as quickly as possible, but no later than 14 days from receipt of the referral.

c. Completes Adult Services Client Assessment with the Applicant. The CCDA case manager should complete an Adult Services Client Assessment with the applicant using the Adult Services Client Assessment Form (CF-AA 3019), within 14 days of the receipt of an appropriate CCDA referral. The assessment will determine the client's level of functioning, existing resources, service needs and barriers to meeting those needs. An assessment completed for a DCF client subsequently referred to the CCDA program from another DCF program, can be used if the assessment was made within 90 days prior to CCDA program receipt of the referral.

d. Assesses the Applicant for Fee Collection. If the CCDA applicant is determined eligible and has an income that is above the institutional care program eligibility standard, then the CCDA case manager must

assess the applicant to determine the appropriate fee, if any, to be charged for each service delivered. Instructions for fee assessment and the necessary forms to be completed for this process are contained in paragraph 3-7 of this operating procedure.

e. Obtains an Authorized Release of Information Form. The case manager will request that the client complete a Release of Information Form (CF-ES 2613) so that necessary information can be shared with service delivery staff and agencies involved in providing appropriate services.

f. Develops a Care Plan. If the applicant is determined eligible for CCDA services after the Adult Services Client Assessment is completed, the case manager must develop an individualized care plan (CF-AA 1025) and open a case file for the client. Care Plan development and determination of services to be authorized are discussed in chapter 8 of this operating procedure. The care plan, developed with the client, caregiver and immediate family, must contain:

(1) A description of the barriers to the client's daily functioning;

(2) Measurable and clear outcomes desired by members of the care plan team, the agencies and people involved and responsible for service provision; and,

(3) The amount, frequency and duration of the services to be provided.

g. Arranges for Services Needed by the Client. As quickly as possible, the CCDA case manager must arrange for services authorized on the individual care plan. All referral contacts and communication with other state service agencies and with ancillary community resources conducted on the client's behalf must be documented within the narrative of the individual client's case record. The case manager may negotiate for services with the provider through a purchase order or voucher method of payment or the case manager may decide to contract for services. The use of purchase orders and vouchers as CCDA service funding mechanisms is addressed in chapter 11 of this operating procedure. Contracting for CCDA services is addressed in chapter 10 of this operating procedure. In those instances where the CCDA case manager is also the program contract manager, the case manager must discuss the following details with the case management provider agency:

(1) The abilities and functioning barriers of each client to be served by the provider; and,

(2) The service amounts, duration, and intensity of services to be provided.

h. Provides Follow-up. The CCDA case manager must conduct and document, in the case record, follow-up contacts with each new provider to whom a client has been referred for services within thirty days of referral to ensure that services have begun.

i. Maintains Ongoing Communication With Other Agencies. The CCDA case manager will coordinate with other agencies to improve the quality of services to the client, provide valuable information, and save time by preventing duplication of services. Since case management is most often not referral alone, but a planned approach for serving clients over time, it is important that a high level of inter-agency communication and coordination be maintained. This is especially important when multiple agencies provide services to the same client. Case managers are encouraged to meet regularly with other appropriate agencies to staff mutual clients and nurture inter-agency relationships.

j. Documents Case Activities. Good case recording is integral to case management. At any point in the on-going case management process where the CCDA case manager feels a notation should be entered relevant to the case, they should not hesitate to enter it. Cases without ongoing progress notes are considered cases without ongoing action. Progress notes reflect case flow and should be consecutively related to each other so a reader can easily understand the transactions that have taken place. The entries should always be dated accordingly. Progress notes are meant to be concise, to the point, and indicative of pertinent case action. An independent reviewer must be able to identify client status and services, and obtain a good overview of case management. The record may also serve as a tool to track improvement in the performance of the case manager. The following information must be documented in the narrative of the case record:

(1) Follow-up contacts to other service providers regarding services for the client;

(2) Telephone contacts;

(3) Agency contacts in which client information has been released;

(4) Case staffing involving the client;

(5) Client progress or any changes in the client's status; and,
(6) All other pertinent information received or shared relative to the client.

k. Reviews and Monitors Care Plan. Care plan review and home visits must take place at least quarterly, or more frequently depending upon the individual client. The CCDA case manager will establish a care plan review schedule for home visits or face-to-face contact with each client. The CCDA case manager will also monitor for continuity of services and changes in the client's functioning that warrant modification to the care plan.

l. Reassessment of Client. The CCDA case manager must complete an Adult Services Client Assessment (form CF-AA 3019) on each client for case management, as well as care planning and service coordination purposes at least once every year. The entire form is completed initially and annually at reassessment. A new form is used each year. **(This form may be updated once ONLY in a different color ink.)** Reassessment information results are to be used in annually modifying and updating the care plan.

m. Terminates Services. After a review and update of the client's situation, a decision to discontinue a client from services can be made with the client and, when appropriate, with his family or caregiver. Case termination is further described in paragraph 6-5 of this operating procedure.

n. Makes Referrals to Florida Abuse Hotline Information System. CCDA staff and their subcontractors are required by Section 415,103, Florida Statutes to report any knowledge or suspicion of abuse, neglect, or exploitation to the Florida Abuse Hotline Information System. 1-800-96ABUSE or 1-800-962-2873. (Reference CFOP 140-2 for further guidelines.)

6-4 The Case Manager's Development of the Case Record.

a. Definition and Purpose.

(1) The case record is the source document maintained by the CCDA case manager for each client. It contains all of the client information necessary to justify the provision of service(s).

(2) The case manager must update the case record at regular intervals so that accurate and current information is available regarding the client's needs, medical and mental status, next of kin, attending physician, service(s) provided by the CCDA program, and all other agencies serving the client. The case record should provide a brief description of the client so that in the absence of the case manager, continuity of services may be ensured.

b. Contents of the Case Record. The case manager is responsible to ascertain that all case records contain the following information:

(1) A completed Adult Services Client Assessment Form, CF-AA 3019, not more than one year old;

(2) A current care plan, CF-AA 1025, which has been completed at least annually and updated quarterly or more if necessary;

(4) A Financial and Medical Release Form, CF-ES 2613, signed by the client allowing the case manager to make arrangements for the provision of services ;

(5) A copy of the Client Information System (CIS) Form, form CF-AA 3012, containing all pertinent information, not more than a year old;

(6) Documentation of client's disability (per paragraph 2-3 of this operating procedure);

(7) Documentation of the client's income and assessment for fee collection, if applicable;

(8) A copy of the referral/intake form, DOEA Form 111A or CF-AA 1022; and,

(9) A case narrative which includes documentation of referrals made to other community service providers and a summary of client contacts.

6-5. Case Manager Tasks Related to Record Closure/Service Termination.

a. A client's case must be closed for one or more of the following reasons:

(1) Client is no longer eligible (age, disability status); or,

(2) Services are no longer needed: or,

(a) Improvement; or,

(b) Refuses to continue services; or,

(c) Family or other persons intervening; or,

(d) Transferred to other program(s); or,

(3) Change in placement: nursing home, other institution, or hospitalized; or,

(4) Client's behavior is abusive or disruptive; or,

(5) Client refuses to pay assessed fee or account is delinquent; or,

(6) Client moved out of service area; or

(7) Client died.

b. When a client's case is terminated, the CCDA case manager must record a brief explanation of the reason for the termination and the termination date in the case record.

c. When a client has not received any service(s) for a period of six months then the case should be terminated, with appropriate documentation in the case record justifying closure.

d. The termination of services to a client will be reported by updating the Client Information Form (CF-AA 3012).

e. The client shall be notified in writing of the termination of a service(s), except for conditions (3) and (7) above. CF-AA 1021 (Notice of Case Action) may be utilized when notifying the client of termination of services.

6-6 The Role of the CCDA Case Manager Regarding Administrative Hearings. The department is required to provide a system of administrative hearings whereby applicants for, or recipients of, general revenue social services may challenge decisions concerning eligibility or receipt of services made by the department or one of its designated service contract providers.

a. Challenges may be made upon denial of a CCDA application for services or when the Department or provider notifies the CCDA client of any action which would terminate, suspend, or reduce CCDA services which are being received.

b. Service recipients who are dissatisfied with the provision of CCDA services have the right to request an Administrative Hearing.

c. Authority for an Administrative hearing is found in Chapter 120, Florida Statutes, Administrative Procedure Act. Procedures to follow in requesting an Adult Services Administrative Hearing can be found in the

Adult Services Due Process Rights Brochure, CF/PI 140-43, and must be utilized by CCDA staff, applicants and clients.

Chapter 7
COMPLETING A NEEDS ASSESSMENT AND PRIORITIZING CLIENTS FOR SERVICE

(this chapter will be added at a future date)

Chapter 8
CARE PLAN DEVELOPMENT

(this chapter will be added at a future date)

Chapter 9
MAXIMIZING RESOURCES

9-1. Purpose. The purpose of this chapter is to acquaint Adult Services staff with the various state and federally funded service programs which exist in the State of Florida to serve adults with disabilities. Knowledge of these programs will facilitate the integration of interagency services to ensure the most efficient use of Community Care for Disabled Adults funding.

9-2. Determining Appropriateness of a Referral. The case manager's resources and expertise can guide the applicant through the complex community service delivery system and assist him/her in gaining access to the various services and programs available in the community.

a. Information gathered through an initial telephone assessment can help the case manager determine if the referral to Adult Services is appropriate, or if a referral to another agency would be more appropriate.

b. When the initial telephone assessment does not disclose enough information to make such a determination, the case manager will complete a more thorough screening to better identify the applicant's problems and present to him/her useful solutions to those problems. This screening will discern factors impeding the applicant's functional independence, physical and nutritional stability and psychosocial well being which may put the applicant at risk for remaining in the community.

c. The Adult Services referral process for service programs administered by agencies external to Adult Services, and for ancillary community services is outlined in CFOP 140-5, General Casework Practices.

9-3. Staffing to Assure Integrated and Complimentary Service Delivery. The Adult Services case manager may request a staffing of any client case that presents complex medical or service delivery issues.

a. The inter-agency staffing is held to:

(1) Prepare an integrated and coordinated care plan;

(2) Clarify agency roles;

(3) Assign financial and service responsibility; and,

(4) Assure a seamless, complimentary service delivery.

b. The Adult services case manager will act as the lead case manager. The lead case manager will be responsible to:

(1) Conduct a Comprehensive Assessment of the applicant for services;

(2) Request the staffing;

(3) Identify and notify the applicant/family and the agencies or programs appropriate to participate in the staffing;

(4) Make arrangements for the staffing;

(5) Develop a care plan that addresses all the areas of need that were identified through the comprehensive assessment process and that identifies the individuals/agencies who will be responsible for assuring that appropriate services are delivered;

(6) Distribute a copy of the written care plan to all members involved in the staffing; and,

(7) Arrange and conduct at least annual (or more often as determined necessary by the lead case manager) staffing to review the care plan and request reports from each participant in order to facilitate a written update of the care plan.

c. The Adult Services Program Administrator or designee will resolve conflicts that may occur as a result of the staffing. This person will have the authority to make decisions about funding and other issues raised during the staffing that could not be resolved by staffing participants.

9-4. Programs Administered By the Department Of Children and Families.

a. The Home Care for Disabled Adults (HCDA) program provides case management and caregiver subsidy payments as an incentive for a person or group of persons to provide care for an adult who is 18 to 59 years of age and permanently disabled in a family-type living arrangement. It provides three types of subsidies:

(1) A basic subsidy to assist with food and personal needs;

(2) A medical subsidy to reimburse for the cost of prescribed medical care not covered by Medicaid, Medicare or other third party insurance; and,

(3) A special subsidy to assist with the purchase of special high and low-tech assistive devices and specialized medical care.

b. The Adult Cystic Fibrosis Program (ACFP) program goal is to assist with the extraordinary costs incurred directly by adults with cystic fibrosis (CF) and increase the independence, dignity, and quality of life for CF adults. This program provides:

(1) Case Management;

(2) Adult Day Health Care;

(3) Alternative Treatment Therapies;

(4) Pharmaceuticals;

(5) In-Home Care Supplies;

(6) In-Home Care Services;

(7) Personal Care;

(8) Nutritious Food;

(9) Vitamins and Nutritional Supplements;

(10) Out-Patient Preventive/Primary Care; and,

(11) Out-Patient Mental Health Care.

c. The Developmental Disabilities (DD) program provides adults with mental retardation or such conditions as autism, cerebral palsy, spina-bifida or Prader-Willi syndrome with the following community-based and home-based services to prevent or reduce inappropriate institutional care:

(1) Adult Day Training;

(2) Companion Services;

(3) Environmental Modifications;

(4) Occupational Therapy and Assessment;

(5) Personal Emergency Response Systems;

(6) Residential Habilitation;

(7) Specialized Group Homes;

(8) Support Coordination;

(9) Psychological Assessment;

(10) Respite Care;

(11) Wheelchairs and Related Adaptations;

(12)Supported Employment;

(13) Room and Board;

(14) Behavioral Analysis and Assessment;

(15) Homemaker and Chore Services;

(16) Consumable Medical Supplies;

(17) Non-Residential Habilitation;

(18) Personal Care Assistance;

(19) Physical Therapy and Assessment;

(20) Private Duty Nursing;

(21) Speech Therapy and Assessment;

(22) Supported Living Coaching;

(23) Skilled Nursing;

(24) Transportation;

(25) Dental Services;

(26) Family Care Program; and,

(27) Medical Services.

d. The DCF Mental Health (MH) and Substance Abuse (SA) programs offer supportive services to adults who are experiencing mental health or substance abuse problems. Assistance is provided in attaining skills and behaviors needed to function successfully in living, learning, work and social environments. Some of the services offered are:

(1) Case Management;

(2) Assessment;

(3) Primary Medical Care;

(4) Day Care;

(5) Partial Hospitalization;

(6) Transportation;

(7) In-Home and On-Site Services;

(8) Crisis Stabilization;

(9) Prevention/Intervention;

(10) Respite Services;

(11) Supported Housing/Living;

(12) Room and Board with Supervision;

(13) Information and Referral;

(14) Behavioral Health Services; and,

(15) (15) Supported Employment.

e. The Aged or Disabled Adult Home and Community-Based Services (ADA/HCBS) Waiver provides the following services to adults aged 18 through 59 with disabilities and frail persons aged 60 years or older, who meet financial and functional criteria for nursing home placement:

(1) Adult Day Health Care;

(2) Adult Companionship;

(3) Environmental Modifications;

(4) Case Management;

(5) Personal Emergency Response Systems;

(6) Case Aide;

(7) Attendant Care;

(8) Counseling;

(9) Escort;

(10) Respite Care;
(11) Health Support;

(12) Family Training and Support;

(13) Pest Control;

(14) Home Delivered Meals;

(15) Homemaker;

(16) Consumable Medical Supplies;

(17) Risk Reduction;

(18) Personal Care;

(19) Physical Therapy;

(20) Occupational Therapy;

(21) Speech Therapy;

(22) Specialized Medical Equipment and Supplies; and,

(23) Skilled Nursing.

f. The Developmental Disabilities Home and Community-Based Services (DD-HCBS) Waiver provides the following services to individuals with mental retardation and/or developmental disabilities:

(1) Residential Habilitation;

(2) Adult Day Training;

(3) Support Coordination Services; and,

(4) All of services listed in paragraph 9-4c of this operating procedure.

g. DCF also administers the Developmental Disabilities Supported Living Waiver which provides the following services to individuals with mental retardation and/or developmental disabilities who meet nursing home level of care:

(1) Supported Living Coaching;

(2) Personal Care Services;

(3) Environmental Modifications;

(4) In-Home Support Services; and,

(5) Adult Day Programs.

9-5. Programs Administered by the Department of Health.

a. The Children's Medical Services (CMS) program provides services for children with special health care needs. Any child between birth through 21 years of age currently enrolled in Medicaid or a DCF program along with his/her sibling(s) is eligible for the CMS services. Services provided include case management, referral, pediatric screening and specialty clinics. Specialty clinics include, but are not limited to:

(1) Cardiac ;

(2) Hematology/Oncology;

(3) Neurology;

(4) Spina-bifida;

(5) Orthopedic;

(6) Pulmonary/Respiratory Disease;

(7) Gastroenterology;

(8) Aids;

(9) Otolaryngology;

(10) Adolescent and Young Adult;

(11) Renal;

(12) Ophthalmology;

(13) Apnea;

(14) Cerebral Palsy;

(15) Craniofacial;

(16) Cleft lip and Palate;

(17) Diabetes;

(18) Cystic Fibrosis;

(19) Neonatal;

(20) Rheumatic Fever; and,

(21) Pediatric Surgery.

b. The Brain and Spinal Cord Injury (BSCI) program began in 1973 with the organization of a committee for promoting better care to individuals who sustained traumatic brain or spinal cord injury. The committee's first major activity was to have the Florida Legislature establish the nation's first Central Registry requiring that all agencies report brain and spinal cord injuries to the Central Registry. The BSCI Program provides:

(1) Acute Care;

(2) Inpatient and Outpatient Rehabilitation Care;

(3) Transitional Living Services;

(4) Adaptive Equipment;

(5) Home Modifications; and,

(6) Other Services Necessary for Community Reintegration.

NOTE: The funding source for the Brain and Spinal Cord Injury Program is established in legislation through the "Impaired Drivers and Speeders Trust Fund."

c. The Department Of Health also administers the Brain and Spinal Cord Injury (BSCI) Home and Community-Based Services Waiver to adults between the ages of 18 and 64 who meet the state definition of traumatic brain injury and/or spinal cord injury. The BSCI-HCBS Waiver provides the following services to persons with brain and spinal cord injuries:

(1) Personal Care Assistance;

(2) Attendant Care Services;

(3) Companion Services;

(4) Life Skills Training;

(5) Behavioral Programming;

(6) Personal Adjustment Counseling;

(7) Community Support Coordination;

(8) Rehab Engineering Evaluations;

(9) Assistive Technology and Adaptive Equipment; and,

(10) Environmental Accessibility Adaptation.

9-6. Programs Administered By The Department Of Education (DOE).

a. The Division of Blind Services (DBS) program is designed to ensure the greatest possible efficiency and effectiveness of services to the blind. The Division compiles and maintains a complete register of the blind in the state, which describes the condition, cause of blindness, and capacity for education and industrial training, with such other facts as may seem to the division to be of value. The Division:

(1) Assists in finding employment;

(2) Teaches trades and occupations;

(3) Assists in marketing of products made in home industries;

(4) Assists in obtaining funds for establishing enterprises; and,

(5) Assists in activities that contribute to self-support efforts.

b. The Division of Vocational Rehabilitation (DVR) program is focused on employment issues and the workplace. The Division provides the following needed supports to persons capable of working with assistance:

(1) Technical Training;

(2) Post-Trauma Rehabilitation;

(3) Adaptive Technology;

(4) Placement; and,

(5) Probationary Job Coaching Services.

9-7. Non-Profit Organizations Serving Physically Disabled Adults. The Centers for Independent Living (CIL) were created through the mandate of the Rehabilitation Act of 1973 (as amended 1992) to maximize leadership and empowerment among people with significant disabilities. The CIL's provide:

a. Peer Counseling;

b. Information and Referral;

c. Assistive Technology;

d. Individual and Systems Advocacy; and,

e. Independent Living Skills Training.

9-8. Various Social and Civic Organizations Serve Physically Disabled Adults. There are numerous agencies and organizations (both local and national) that provide a wide range of information and referral and direct services to persons with disabilities. It is incumbent upon all DCF program staff to develop resource directories of those agencies in their communities that provide such services. Some examples are:

a. Churches;

b. Hospice;

c. Kiawanis;

d. Shriners;

e. Elks;

f. American Cancer Society;

g. United Cerebral Palsy Association;

h. American Lung Association;

i. Epilepsy Foundation;

j. American Lung Association;

k. Lupus Foundation; and,

l. Numerous others.

Chapter 10
CONTRACT PURCHASE OF COMMUNITY CARE FOR DISABLED ADULTS (CCDA) SERVICES

10-1. Purpose. The purpose of this chapter is to outline statewide procedures to be used to contract with community providers for CCDA client services. It is important that procedures for these activities be consistent and maintained in a standardized format.

10-2. Reference and Definition. This chapter intentionally omits instructions or procedures described in CFOP 75-2, Contract Management System for Contractual Services. To advance the case manager's support of the contract manager and for informational purposes, the CCDA case manager may find, in CFOP 75-2, the policies and procedures for the procurement of contractual services starting with the purchasing process and proceeding through writing the contract document, executing and monitoring it.

10-3. Choosing to Contract for CCDA Services.

a. When. Districts/Regions may elect to enter into contracts with provider agencies when the frequency, volume or supplier of services can be predetermined, and both delivery and performance are predictable. When performance and cost uncertainty exists, the case manager may decide to purchase the service(s) by means of purchase order or voucher. Purchase of services through a departmental purchase order or by way of voucher will be discussed in Chapter 11 of this operating procedure.

b. Why. Contracting and pricing policies are based on the assumption that the type of contract selected directly influences the provider's performance. Providers must be motivated to perform efficiently and to control costs through good management decisions made on a daily basis. The contracting process exists only to help the department deliver effective human services.

c. How. There are two broad categories of contract types:

(1) Fixed Price Contracts. With this type of contract, the provider guarantees the performance of the contract. This contract is an agreement to pay a specified price when the services called for by the contract have been delivered and accepted. No price adjustment is made for the original work after award regardless of the provider's actual cost experience in performing it.

(2) Cost Reimbursement Contracts. With this type of contract, the scope of the work can not be adequately described for the provider to project performance; therefore, he or she produces agreed upon products to be submitted at agreed upon intervals for reimbursement. The Department reimburses the provider for actual costs incurred either upon completion of the contract or by these periodic invoices. The Department must audit each periodic invoice for allowable charges and closely track that contract specifications are being met to authorize the provider to continue performance under the contract.

d. Who. The contract manager is responsible for enforcing the performance of administrative and programmatic terms and conditions of the contract. The district/region program specialist for the CCDA program must assist the district/region contract manager in ensuring that contracts with CCDA providers for the provision of CCDA services are:

(1) Developed in a fashion so as to ensure that the department protects the funds it disburses;

(2) Developed to derive the maximum return of services from those funds; and,

(3) Developed in compliance with applicable state and federal laws, rules, and regulations governing the elected funding procedure for services.

10-4. The District/Region Program Specialist and the Contract Manager as a Team.

a. It is the district/region program specialist's responsibility to share his or her disability expertise with the contract manager during contract development. The program specialist has valuable knowledge of the disabled adult provider network that can assist in keeping contract performance costs down and service quality up. He or she must work in concert with the district/region contract manager to:

(1) Promote service delivery flexibility when the standard delivery methods don't accommodate;

(2) Procure access to appropriate service providers and coordinating a seamless service delivery continuum; and,

(3) Foster creativity, resourcefulness, communication, and client concern between network providers of services to disabled adults.

b. The district/region program specialist must provide the contract manager with:

(1) Clear and detailed service specifications which meet the client's needs;

(2) Acquired knowledge of available service providers and service options;

(3) Warning of any anticipated program or client problems which may materialize during the contract period; and,

(4) Any client specific information which will assist the contract manager in contract negotiations.

10-5. District/Region Contracting Responsibilities for CCDA Program Specialists.

a. Conducting the Community Needs Assessment. A needs assessment can identify unmet needs in the community, provide evidence of support for policy options, and increase public involvement in policy making. It is the district/region program specialist's responsibility to conduct an annual community needs assessment of the adults with disabilities residing within the district/region three months prior to each new fiscal year.

(1) If done well, the needs assessment is both a process and a method.

(a) As a process, it can build leadership, group cohesion, and a sense of local involvement in the community.

(b) As a method, the needs assessment is a tool that helps a community plan for and implement strategies that make the best use of existing resources and offer the best response to local conditions.

(2) A disabled adults needs assessment should answer five questions:

(a) What are the needs adults with disabilities, and how well are local agencies meeting those needs?

(b) How well are disabled adults doing in the community?

(c) How do consumers and providers view the existing service delivery system?

(d) What services exist, and what gaps and overlaps make it difficult for adults with disabilities to get needed help?

(e) Are other reform initiatives that focus on disabled adult issues underway, and how can their efforts be linked?

(3) The traditional approaches to needs assessment focus on community assets, resources, and activities as well as gaps, barriers, or emerging needs. Effective methods for data gathering for an assessment include focus groups, community forums, surveys, and action research. Here are brief descriptions of the three most popular methods:

(a) The survey is one of the more popular approaches to needs assessment. While surveys can provide excellent information for needs assessment, surveys require expertise, time, and resources to be accurate and relevant and usually produce a lower response rate than say, community forums. Survey mode may be: sent by mail and self-administered, face-to-face personal interview, conducted by telephone or made available by web invitation. Each of these modes has its advantages and disadvantages in terms of: ease of administration, staffing requirements, training and supervision, cost, and reliability of results.

(b) Community forums, another type of needs assessment, provide participants a vehicle for expressing their opinions on community issues. The forums help validate assumptions and offer community agencies the ability to assist in assessing program needs and gaps. Community forums are conducted to gain a better understanding of the public's perception of the needs and desires of its adults with disabilities. Forums work best when they occur at convenient times for working family members and in locations accessible by public transportation. A discussion guide should be used to keep participants on task. The discussion guide contains the questions that will be asked to participants during the discussion sessions. The extent to which the process is participatory and inclusive will affect the degree to which your strategies reflect community concerns.

(c) Focus groups can also be used to do needs assessments. Focus groups are structured, moderated discussions that bring together small groups of people (usually six to 12) in neutral settings

to talk about specific issues. Effort should be made to recruit participants from a variety of settings adequately representing the disabled adult population and the community providers serving this population. One DCF staff member moderates the group discussion, one facilitates information coordination and gathering, and another serves as note-taker. All focus groups should be tape-recorded. Focus group participants should be informed that, since the sessions are being taped to ensure accurate recall, they should not mention names or give identifying information during discussions. Confidentiality will be maintained by using first names only. For quality output from the process, and to compile enough data to validate the assessment, four to six focus groups should be consecutively conducted. Each focus group should be steered by a discussion guide.

b. Processing Needs Assessment Data into a Plan. The district/region program specialist is responsible for analyzing the data from the surveys and focus groups. He or she then must use the findings of that analysis to develop an Annual District/Region Service Plan which will serve as a workable infrastructure for a seamless, coordinated service delivery system for adults with disabilities. This plan should:

(1) Supply general demographic characteristics of the region;

(2) Identify the number of adults with disabilities in their district/region in need of in-home services;

(3) List the specific service needs of the adults with disabilities residing in the district/region who have voiced a service need;

(4) Compile a listing of known private service providers, volunteer agency staff, religious organizations, social organizations and other existing state and county agencies available to meet the needs of their community's adults with disabilities;

(5) Compile a listing of standard unit cost rates for identified community and private provider services; and,

(6) Project service needs and spending trends for their adult clients for the coming fiscal year.

Chapter 11
PURCHASE OF COMMUNITY CARE FOR DISABLED ADULTS SERVICES WITH VOUCHERS AND PURCHASE ORDERS

11-1. Purpose. The purpose of this chapter is to establish the district's/region's responsibility with regard to the use of vouchers and purchase orders and to define the CCDA program's minimum standards for management of the vouchering process, its obligations, its payables and its disbursements.

11-2. Voucher and Purchase Order Authority. The legislature has granted authority in statute for the department to negotiate, enter into, and execute purchases, contracts and agreements for CCDA services. Florida Statutes 410.602 states that the department is to encourage innovative and efficient approaches to program management and service delivery.

11-3. When to Use a Voucher or Purchase Order.

a. When the frequency, volume or supplier of services can not be predetermined and cost uncertainty exists, districts/regions may elect to purchase the service(s) by means of purchase order or voucher. According to subsection 287.057(3)(f), F.S., program service purchases which total, on a completed project cost basis less than $25,000 do not require the use of the competitive procurement process.

b. CCDA district/region staff may elect to use vouchers or purchase orders as payment to vendors for any goods or services that meet the above statutory criteria and are not covered by an existing contract of service.

11-4. Function of Vouchers and Purchase Orders.

a. Purchase Orders. A purchase order establishes a legal contract between the department and the vendor for an encumbrance upon the department for service/goods delivered by the vendor. It is used when the service/goods being purchased will be needed on an ongoing basis.

(1) The purchase requisition, which is a pre-numbered triplicate copy form, is the first step of an official purchase order.

(2) A properly approved purchase requisition permits the department to make vendor purchases, to pay vendors for goods and services when received, and to charge the appropriate program account.

(3) Purchase requisitions should be checked to ensure:

(a) Completeness;

(b) Correctness/accuracy;

(c) Copies of all relevant documents (as per the requisition form instructions) are attached;

(d) Account numbers are correct (errors may lead to delay in the issue of purchase orders); then,

(e) The original and duplicate copies are sent to the purchasing office for processing.

(4) Where the purchase requisition is for the purchase of direct client services, a copy of the Client Service Authorization Form must be attached to the purchase requisition.

(5) It is the responsibility of the authorized financial delegates to satisfactorily determine in respect to each requisition:

(a) That a logical and justifiable choice has been made with regard to price, quality, quantity and delivery; and,

(b) That funds are available to cover the cost of the purchase.

b. Vouchers. A voucher represents a negotiated payment owed by the department to the vendor for prior authorized service/goods delivered by the vendor. Vouchers are used for unexpected, one-time purchases.

(1) Payments for the purchase of goods or services are based on vendor's invoices.

(2) Such payments are made when there is reasonable assurance that the commodity or service has been delivered as specified on the Client Service Authorization Form and received in an acceptable condition by the eligible client it was intended for.

(3) Each district/region reviewing or approving invoices for payment is responsible for developing and implementing procedures to provide for the timely processing of vendor invoices. Acceptable guidelines for payment procedures are outlined in paragraph 11-7 of this chapter.

(4) District/region vouchering procedures must begin with the stages of vendor selection, and delineate all accounting processes from district/region voucher review and approval through submitting vouchers to the State Comptroller who in return disperses state warrants (cash) to the vendor.

(5) Appendix B to this operating procedure offers an example invoice form to copy and use or to follow when creating a district/region specific invoice form. Invoices created by the district/region must include, minimally, all information fields as contained on the example invoice form.

11-5. Steps Which the District/Region Program Office Must Follow for Service Procurement.

a. Step One. The Program Specialist must identify the service need(s) of the eligible client and the required conditions for service delivery.

(1) The client's Care Plan will define the service need and conditions.

(2) The availability of provider resources and the district/region budget will establish the extent to which that need can be met.

b. Step Two. The Program Specialist must secure the availability of funding for the identified need.

(1) Review prior year's total expenditures.

(2) If the district/region had experienced over-expenditure the prior year, or was compelled to transfer funds from another source to realize their client obligation, adding new clients or attempting to expand service delivery this new fiscal year would not be advisable.

(3) If the district's/region's prior year allocation adequately met the district's/region's identified client obligation for that fiscal year, then prudent consideration may be given to expanding service delivery if such delivery can be reasonably annualized.

c. Step Three. The Program Specialist is ready to select a service provider.

(1) Potential providers must be screened to ensure adequate competition (comparative price and quality) and to ensure that necessary qualifications will be met to accomplish intended service delivery.

(2) The Florida Vendor Registration System is a good place to start the search for innovative, reliable, and competitive vendors who have know-how and can demonstrate more effective and efficient ways of satisfying the state's requirements. Use of the Vendor Registration System allows fair and open competition to exist in all procurement activities in order to avoid the appearance of and prevent the opportunity for favoritism and to inspire public confidence that purchase agreements are awarded equitably and economically.

(3) Other sources to research for provider resources are; local Information and Referral Directories, district/region list of currently active providers, file list of reliable, past providers, and the phone book.

(4) When the transaction will involve delivery of a direct client service, it is important that the selected provider's proposal:

(a) Comply with performance specifications developed by the case manager;

(b) Contain a provider's management approach (choice of funding mechanism) efficient and logical to perform the required services; and,

(c) Support that the provider's organization appears stable and capable of meeting the staffing levels necessary to sustain service performance?

(5) When the transaction will involve purchase of a durable/non-durable item or medical equipment, documentation must be kept on file that:

(a) A comparative price analysis been conducted to compare the offerer's price with at least three other provider prices for a similar item; or,

(b) A comparison been made to a past purchase price by the Department to establish reasonableness; and,

(c) A value analysis been completed to look at the item and the function it performs so you can determine if the product, as it is now produced is the best possible product in terms of value or if there would be a better substitute?

(6) **Be sure that you feel comfortable with an estimate before relying on it as a basis for determining a price to be fair and reasonable.**

d. Step Four. The Program Specialist will complete a Client Service Authorization form. This form documents:

(1) Demographic information on the provider agency from whom the service/equipment purchase is being made;

(2) Demographic information on the client for whom it is being purchased; and,

(3) The authorized units and delivery times and conditions under which the service will be performed.

11-6. Authorization for Payment Procedures.

a. The District/Region Program Office may approve for payment only those invoices that show, through verification of an approved method, that the vendor and unit of service was priorly authorized, the goods/service has been delivered and that an eligible client has received the goods/services.

b. Before presenting the vendor's invoice to his/her Supervisor for review for payment, the case manager must validate that the services being billed for are the services listed on the Client Service Authorization form and that the vendor billing for those services has received prior authorization to bill for the services. The case manager will review:

(1) Client Service Authorization Form. The case manager must verify that the units of service delivered are only the units identified in the Client Service Authorization Form and are designed to meet the care plan needs of the client. The Service Authorization Form lists all services approved for purchase and the vendor selected to deliver the service/good.

(2) Supporting Documentation. The case manager must review the reference file of vendors for supporting documentation of; selected vendor's original bid (showing service/good being purchased and the cost per unit) and related correspondence validating selection of said vendor, an objective record of past vendor experiences with the selected vendor, all vendors contacted for estimates for this service/goods and their quotations, any controversial bid awards and justification for selection of said vendor and examples of prior vendor approvals for comparable goods/services.

c. To ensure the department's economic and efficient procurement of services, the department approves vouchers for payment only if one or both of the above sources is attached to the submitted voucher.

d. To ensure that payment transactions are approved without any influence and to avoid the appearance of a conflict, the following district/region authority levels should review all CCDA invoices prior to authorization of payment (see appendix C for a flowchart example of the District/Region Program Office Invoice Processing Procedure):

(1) Human Service Counselor (case manager); and/or,

(2) Program Operations Administrator; and/or,

(3) Program Administrator; and, if applicable,
(4) Regional Processing Center in Tallahassee.

e. The reviewing authorities must verify that:

(1) Each unit of service delivered by the vendor was delivered according to departmental standards of service delivery; and,

(2) The client accepted and received the good(s) or service(s) being billed for. **Authorization for payment may not be made based exclusively on a vendor's monthly statement or other summary of amounts.**

f. A copy of the signed and approved CCDA voucher for general revenue payment to the vendor must be distributed to each of these four entities:

(1) Accounting;

(2) State Comptroller;

(3) Vendor; and,

(4) District/Region Unit.

11-7. Payments To Vendors.

a. Vouchers for payment must be supported by a valid purchase order or, in instances where a specific purchase order was not issued, by an original copy of the vendor's invoice.

b. Written notice is mailed to a vendor if an invoice is not approved or if a submitted invoice is inaccurate for any reason.

Chapter 12
CONTRACT MONITORING

(this chapter will be added at a future date)

Chapter 13
MONITORING OF VOUCHERS AND PURCHASE ORDERS

(this chapter will be added at a future date)

Chapter 14
GLOSSARY

14-1. Purpose. It is important to understand the clinical terminology related to eligibility determination for CCDA services and the acquisition and delivery of those services to adults with disabilities. This chapter contains a list of the most common terms used in the administration of the CCDA program. Some of these definitions are adopted from the contract instruments developed by the department's Office of Contracted Client Services, and some are legislatively established.

14-2. Definitions.

a. "Activities of Daily Living" means those basic activities performed in the course of daily living, such as dressing, bathing, grooming, eating, toileting, and ambulating.

b. "Adult Day Health Care" means an organized day program of therapeutic, social and health activities, and services provided to disabled adults for the purpose of restoring or maintaining optimal capacity for self care.

c. "Adult Day Care" means a program of therapeutic social and health activities and services provided to adults who have functional impairments, in a protective environment that provides as non-institutional an environment as possible.

d. "Case Management" means a client centered series of activities which includes planning, arrangement for, and coordination of appropriate community-based services for an eligible Community Care for Disabled Adults client. Case management is an approved service, even when delivered in the absence of other services. Case management includes intake and referral, comprehensive assessment, development of a service plan, arrangement for services and monitoring of client's progress to assure the effective delivery of services and reassessment.

e. "Chore Service" means the performance of house or yard tasks such as seasonal cleaning, essential errands, yard work, lifting and moving furniture, appliances or heavy objects, simple household repairs which do not require a permit or specialist, pest control and household maintenance.

f. "Client" means a service eligible adult at least eighteen years old, but under sixty years of age, who has one or more permanent physical or mental limitations that restrict his/her ability to perform normal activities of daily living, and impede his/her capacity to live independently or with relatives or friends without the provision of Community Care for Disabled Adult services.

g. "Contract" means a formal written agreement between the department and an individual or organization for the procurement of services. A *contract* consists of the Standard Contract, Program Specific Model Attachment I (PSMAI)/Attachment I, *including special provisions where appropriate*, plus any other attachments or exhibits deemed necessary. Per Chapter 287, Florida Statutes, a contract must be signed by both parties prior to services being rendered.

h. "Emergency Alert Response Service" means a community based electronic surveillance service system established to monitor the safety of individuals in their own homes and which alerts proper assistance to the client in need.

i. "Escort Service" is the personal accompaniment of an individual to and from service providers or personal assistance to enable clients to obtain other required services needed to implement the service plan.

j. "Group Activity Therapy" is a service provided by a professional staff person to three or more eligible clients and may include, but is not limited to the following activities: physical, recreational, educational, social interaction, and communication skill building through the use of groups. The purpose of this service is to prevent social isolation and to enhance social and interpersonal functioning.

k. "Health Care Professional" means any person who has completed a course of study in a field of health care, such as a nurse. The person is usually licensed by a governmental agency, such as a board of nursing, and becomes registered or licensed in that health care field. In some instances, the person is certified by a state regulatory body, such as with a certified nurses' aide.

l. "Home Delivered Meals" means a hot or other appropriate, nutritionally sound meal that meets one-third of the current daily recommended dietary allowances served in the home to the homebound disabled adult.

m. "Home Health Aide Service" means a health or medically-oriented task furnished to an individual in his residence by a trained home health aide. The home health aide must be employed by a licensed home health agency and supervised by a licensed health professional who is an employee or contractor of the home health agency.

n. "Homemaker Service" means the performance of or assistance in accomplishing household tasks including housekeeping, meal planning and preparation, shopping assistance, and routine household activities by a trained homemaker. With district approval, it may include the purchase of home and/or cleaning supplies needed for the delivery of services. Otherwise, clients are responsible for purchasing their own cleaning supplies.

o. "Home Nursing Service" means part-time or intermittent nursing care administered to an individual by a licensed professional or practical nurse or advanced registered nurse practitioner, as defined in Chapter 464, F.S., in the place of residence used as the individual's home, pursuant to a plan of care approved by a licensed physician.

p. "Institutional Care Program (ICP)" means a state program that provides financial supplements to disabled adults and elderly who are determined eligible for a nursing home level of care.

q. "Interpreter Service" means assistance in communicating provided to the disabled adult client with a speech or hearing impairment or language barrier.

r. "Medical Equipment or Supplies" means durable or non-durable goods purchased for the purpose of enabling the client to remain in his own home.

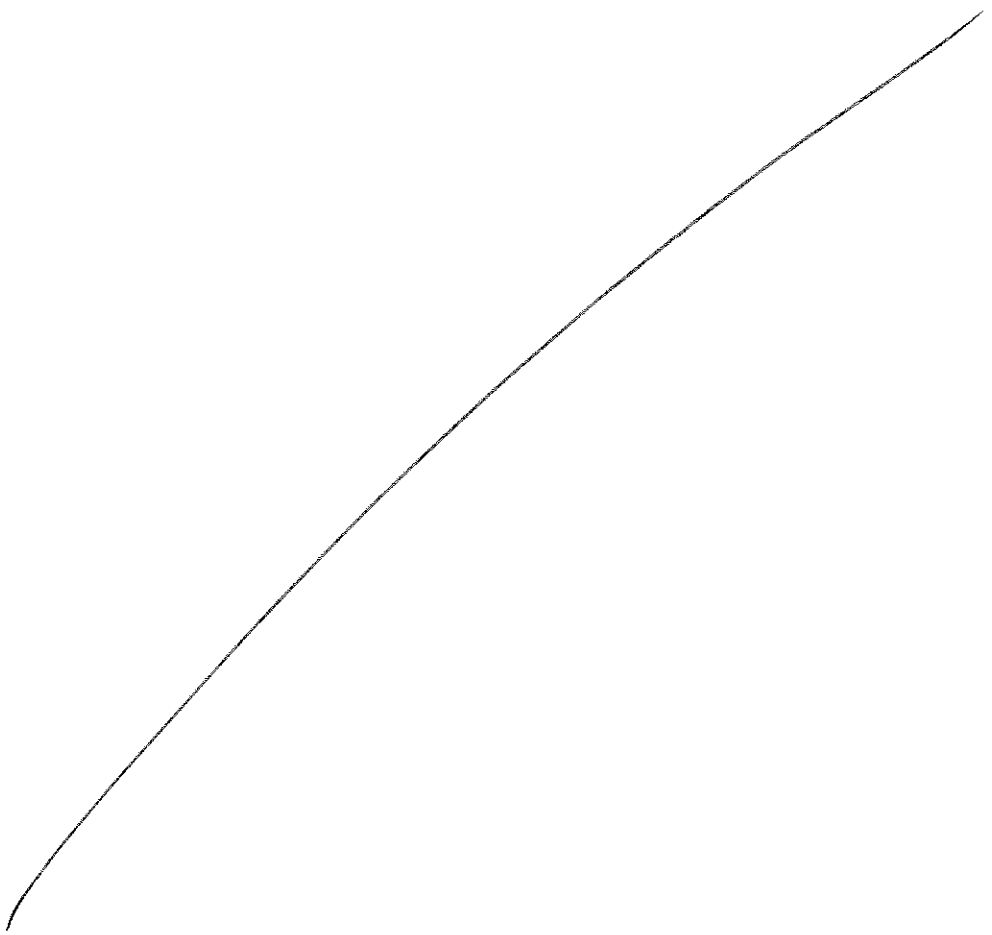
s. "Medical Therapeutic Services" means those corrective or rehabilitative services prescribed by a physician or nurse practitioner licensed in the State of Florida. Provided by a professionally licensed, registered or certified individual, these services are designed to assist the client to maintain or regain sufficient functional skills to live independently. Such therapies include physical, occupational, speech - language therapy, and respiratory therapy.

t. "Personal Care Services" include, but are not limited to, services as: individual assistance with or supervision of essential activities of daily living, such as bathing, dressing, ambulating, supervision of self-administered medication, eating, and assistance with securing health care from appropriate sources. Personal care services shall not be construed to mean the provision of medical, nursing, dental or mental health services by the personal care service staff.

u. "Physical/Mental Exam" is the purchasing of services of a physician or psychologist/psychiatrist/mental health professional for clients who would otherwise be unable to purchase services.

v. "Respite Care" means relief or rest for a caregiver from the constant supervision, companionship, therapeutic and personal care on behalf of a client for a specified period of time. The purpose of the service is to maintain the quality of care to the client for a sustained period of time through temporary, intermittent relief of the primary caregiver.

w. "Transportation Service" means the transport of a client to and from service providers or community resources.



Fee Assessment

When a client is determined eligible for services and services are available and his/her income is over the institutional care program eligibility standard, a fee for services must be assessed. In order to assess a fee the following steps must be taken.

a. Monthly income must be determined, including: earnings, payments and pensions. Assets are not included.

b. Expenses shall be determined, including: housing, utilities, telephone, food, medical expenses, transportation, insurance and other necessary expenses. The household expenses will be in relation to what percentage the client's income is to total household income.

c. Necessary expenses, as determined in b., shall be subtracted from the monthly income to determine the applicant's disposable income and overall ability to pay. Applicants who have $200.00 or more remaining after expenses are subtracted shall be assessed a fee.

d. The fee assessed will be equal to 10% of the disposable income of the client, or the total unit cost of the services(s) to be received, whichever is less. The fee will be assessed monthly. The unit cost used for this exercise will be the statewide, average unit cost for that service as provided by Central Office.

e. Clients shall have the opportunity to perform volunteer services in lieu of making payments.

f. Redetermination of the client's ability to pay shall be made on an annual basis. The client may request redetermination based upon a change of financial status.

EXAMPLE A

Client A is a 40 year old white male, who lives with his wife and two children. He was stricken with multiple sclerosis four (4) years ago. He spends the majority of his time in a wheelchair. He can ambulate with two canes, but his gait is poor and it is very fatiguing to him.

He was referred to CCDA by FPSS. They had received a referral from a concerned neighbor. Client A is left alone all day with no caregiver.

Client A has an income of $1,193.

It has been determined that this client is priority and there is an opening at the adult day health care program. Client A's income is $1,193 and his expenses are as follows:

Rent	$475
Utilities	70
Phone	50
Food	350
Vitamins (for MS)	50
Gas	100
Laundry	60
Misc. (sundries)	50
Insurance	100
	$1,305

Client A's costs are more than his income, therefore no fee would be assessed.
(1,193 – 1,305 = – 112)

EXAMPLE B

Client B is a 35 year old white male who lives by himself. He is paraplegic resulting from a diving accident six years ago. He has no family nearby, but his neighbor is quite helpful when he needs assistance. He drives an adapted van and works a little bit out of his home. He is in need of homemaker services.

Client B has an income of $1,548

It has been determined that this client is priority and there is an available homemaker. Client B's income is $1,548 and his expenses are as follows:

Rent	$475
Utilities	100
Phone	50
Food	150
Medicine	50
Gas	100
Laundry	60
Misc. (sundries)	50
Insurance	100
	$1,135

Client B's disposable income is $413 (1,548 – 1,135 = 413). Therefore, he must pay either $41.30 or the total unit cost for homemaker service he will receive from the provider, which is $9.44 x five units of service, or $47.20. Since the unit cost is more, the client will pay $41.30 every month toward the cost of the service he receives.

If a client was to receive more than one service then the total of all the unit costs or 10% of his disposable income would be assessed, whichever is less.

ASSESSED FEE WORKSHEET

CLIENT(S) NAME(S):_____

1. INCOME(S) AND SOURCE(S):

SOURCE	AMOUNT (NET MONTHLY)
_____	$_____.___
_____	$_____.___
_____	$_____.___
_____	$_____.___

2. TOTAL INCOME NET (Total of Net Monthly Amount Column) ..... (2) $_____.___

3. MONTHLY EXPENSES:

A. FOOD.....$_____.___
B. RENT/HOUSING.....$_____.___
C. UTILITIES.....$_____.___
D. MEDICAL CARE/MEDICINES.....$_____.___
E. INSURANCE (S).....$_____.___
F. TRANSPORTATION.....$_____.___
G. TELEPHONE.....$_____.___
H. OTHER (SPECIFY PER INSTRUCTIONS)

_____.....$_____.___
_____.....$_____.___
_____.....$_____.___

4. TOTAL EXPENSES (Total of lines A through H)..... (4) $_____.___

5. NET DISPOSABLE INCOME (Subtract line 4 from line 2)..... (5) $_____.___

_____ _____
Prepared By Date

Sample Invoice

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF ADULT SERVICES
MONTHLY REQUEST FOR PAYMENT AND EXPENDITURE REPORT

Exhibit _____

PROVIDER FED. ID # _____

NAME AND MAILING ADDRESS OF PAYEE:

CONTRACT AMNT.:_____
REIMBURSEMENT YTD.:_____
CONTRACT BALANCE:_____
DATE:_____
CONTRACT #:_____
PERIOD OF SERVICE PROVISION:_____

Name of Service or Description of Materials	Units/ Quantity	Amount Per Unit/ Episode	Total Amount Due

Total Match Required for Contract:_____

		This Month	YTD
Local Cash Match			
Local In-Kind			
Total Deductions			
Remaining Match Balance			

Total Payment Requested

Signature of Preparer:_____ Date Completed:_____

Approved By:_____
Title:_____

* If this invoice is for a fixed price contract, the request for payment will be determined by dividing the length of the contract into the contracted amount (example: $12,000 [allocation] divided by 12 months [the length of the contract] = $1,000 payment request). On a cost reimbursement contract, the payment request will be the monthly request expense.

CHILDREN AND FAMILIES USE ONLY

Date Invoice Received:_____

Approved By:_____ Date:_____

ORG	EO	OBJ	DESC.	OCA	
AMNT.					

Report Flowchart
Community Care for Disabled Adults Program

Report Due	From Whom	To Whom	Due Date(s)
Quarterly Cumulative Summary Reports:			
- three month	*See provider requirements below.	Central Office	October 30
- six month	*See provider requirements below.	Central Office	February 15
- nine month	*See provider requirements below.	Central Office	April 30
- twelve month	*See provider requirements below.	Central Office	August 15
Contract Monitoring Schedule	District/Region Program Office(s)	Central Office	July 30th for each new fiscal year
Contract Monitoring Reports	District/Region Program Office(s)	Central Office	Due annually on all CCDA contracts. Due within 30 days of the District exit interview with the provider. Required corrective action plans (CAP's) are due within two weeks of district receipt of the corrective action plan.
Annual District Service Plan	District/Region Program Office(s)	Central Office	Draft plan must be submitted by May 1 of the preceding fiscal year and a final plan must be submitted by September 30 of the year being planned for.
Provider Update Report	District/Region Program Office(s)	Central Office	July 15th for each new fiscal year

* Only providers of case management services must submit Quarterly Cumulative Summary Reports to the District/Region Program Office. These reports are to include management program data (e.g., client identifiable data) according to negotiated instructions provided by the districts/regions.

Required submission dates of Quarterly Cumulative Summary Reports by the provider to the District/Region Program Office may be negotiated through the provider contract.

Exhibit B
Contract KG051

INDIVIDUAL PROVIDER CCDA CUMULATIVE SUMMARY REPORT

Name of Contract Manager:_____
Name of Program Specialist:_____
District: _____
Region: _____

Reporting Period:
_____ 3 Month
_____ 6 Month
_____ 9 Month
_____ 12 Month

I. Expenditures

(1) Total CCDA dollars contracted/PO'd: _____

(2) Total dollar amount spent this quarter: _____

(3) Total amount spent to date:_____

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

Overall Unduplicated Number of Clients Served This Quarter: _____

II. Services

A. Units of Service

Name of Service	Contracted/PO Unit Objective	Units Provided This Quarter	Total Units Year to Date	% Achieved
Case Mgmt				
Homemaker				
Personal Care				
Meals				

Comments:

B. Unduplicated Clients Served

Name of Service	Projected Number of Clients To Be Served	Undupl. # Served This Quarter	Total # Served Year to Date	% Achieved
Case Mgmt				
Homemaker				
Personal Care				
Meals				

Comments:

III._____
Report Prepared By

_____

District Program Office Signature/Date

Monroe County In Home Services

Exhibit C
Contract KG051

REPORTING MONTH:													
CLIENTS	SERVICE UNITS Case Mgmt	Unit Cost	Monthly Cost	Meals	Unit Cost	Monthly Cost	PCA	Unit Cost	Monthly Cost	Home making	Unit Cost	Monthly Cost	Total Monthly Cost
		$47.73	$0.00		$5.10	$0.00		$51.11	$0.00		$27.11	$0.00	#REF!
Monthly Totals			$0.00			$0.00			$0.00	$0.00		$0.00	#REF!

DEPARTMENT OF CHILDREN AND FAMILIES **Exhibit D**

ADULT SERVICES OFFICE

MONTHLY REQUEST FOR PAYMENT AND EXPENDITURE REPORT

PROVIDER FED. ID # _____

NAME AND MAILING ADDRESS OF PAYEE:

CONTRACT AMNT.:_____
REIMBURSEMENT YTD.:_____
CONTRACT BALANCE:_____
DATE:_____
CONTRACT#:_____
PERIOD OF SERVICE PROVISION:_____

NAME OF SERVICE OR DESCRIPTION OF MATERIALS	UNITS/ QUANTITY	AMOUNT PER UNIT/ EPISODE	TOTAL AMOUNT DUE

TOTAL MATCH REQUIRED FOR CONTRACT:_____

		THIS MNTH.	YTD.
LOCAL CASH MATCH			
LOCAL IN-KIND			
TOTAL DEDUCTIONS			
REMAINING MATCH BALANCE			

TOTAL PAYMENT REQUESTED	

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

SIGNITURE OF PREPARER_____DATE COMPLETED_____

APPROVED BY_____TITLE_____

*IF THIS INVOICE IS FOR A FIXED PRICE CONTRACT, THE REQUEST FOR PAYMENT WILL BE DETERMINED BY DIVIDING THE LENGTH OF THE CONTRACT INTO THE CONTRACTED AMOUNT (EX.-$12,000[ALLOCATION] DIVIDED BY 12 MONTHS [THE LENGTH OF THE CONTRACT]=$1,000 PAYMENT REQUEST) ON A COST REIMBURSEMENT CONTRACT THE PAYMENT REQUEST WILL BE THE MONTHLY REQUEST EXPENSE.

CHILDREN AND FAMILIES USE ONLY

DATE INV. RCD._____

APPROVED BY:_____ DATE_____

ORG	EO	OBJ	DESC.	AMNT.	OCA	

Florida Department of
CHILDREN & FAMILIES

District Tracking Number (for CRITICAL incidents)
11 (District) __ __ YEAR __ __ __ __ Sequence Code
Check if CLOSED ____
Program Code: AS, DA, DD, ESS, FS, MH, SA __ __ __

DISTRICT 11 INCIDENT REPORT

EXHIBIT E

(Critical incidents must be reported to District Administrator within 24 hours of notification.) CHECK IF CRITICAL ☒

CONFIDENTIAL

WARNING: The information contained in this report is confidential. You are hereby notified that dissemination, distribution, or copying of this document is strictly prohibited, unless authorized by the Department of Children & Families.

I. IDENTIFYING INFORMATION

Reporting Party Phone #:_____ Date of Incident ___/__/___ Time of Incident_____
Reporting Party Name _____
District Program Area: _____ DCF Unit # _ _ _ _ _ _
Specific Program: check all that apply
☐AMH ☐AS ☐ASA ☐CMH ☐CSA ☐DA ☐DC ☐DD ☐ ESS ☐ FS
Please respond to one of the following as appropriate.
a. Contract Provider Name_____
b. Foster Home Name_____ c. DS Home Name _____
d. DCF Facility Name_____ e. Other Name _____
Is this a licensed facility? ☐ Yes ☐ No ☐ Don't know.
Specific location/address where incident occurred:
_____

II. TYPE OF INCIDENT

Check one box only.

1. ☐ Abuse/Neglect/Exploitation
2. ☐ Aggression/Threat
3. Altercation:
   ☐Client/client ☐Client/staff ☐ Staff/staff
4. ☐ Baker Act
5. ☐ Bomb Threat
6. ☐ Client Injury
7. ☐ Client Death
8. ☐ Contraband
9. ☐ Criminal Activity
10. ☐ Damage
11. ☐ Drugs
12. ☐ Elopement/Runaway
13. ☐ Emergency Room Visit
14. ☐ Escape
15. ☐ Hospital Admission
16. ☐ Illness
17. ☐ Media Coverage
18. ☐ Medication Issue
19. ☐ Misconduct
20. ☐ Physical Aggression
21. ☐ Self-Injurious Behavior
22. ☐ Sabotage
23. ☐ Sexual Battery
24. ☐ Suicide Attempt
25. ☐ Suicide Ideation/Threat
26. ☐ Theft
27. ☐ Vandalism
28. ☐ Other Incidents_____

III. PARTICIPANT(S) / WITNESS(ES) (Please check one from each side)

FIRST Name	LAST Name	SS#	Birth Date	Race	Gender	Client	Employee	Other	Participant	Witness	Other
			__/__/__			☐	☐	☐	☐	☐	☐
			__/__/__			☐	☐	☐	☐	☐	☐
			__/__/__			☐	☐	☐	☐	☐	☐

CONFIDENTIAL

III. PARTICIPANT(S) / WITNESS(ES) (Please check on from each side)

FIRST Name	LAST Name	SS#	Birth Date	Race	Gender	Client	Employee	Other	Participant	Witness	Other
			__/__/__			☐	☐	☐	☐	☐	☐
			__/__/__			☐	☐	☐	☐	☐	☐
			__/__/__			☐	☐	☐	☐	☐	☐

IV. DESCRIPTION OF INCIDENT

Give Detailed Account - (Who, What, When, Where, Why, How) - Add Pages If Necessary

V. CORRECTIVE ACTION AND FOLLOW UP

Immediate corrective action taken

Is follow-up action needed? NO☐ YES☐ If yes, specify:

VI. INDIVIDUALS NOTIFIED

EXTERNAL NOTIFICATION

Agency Notified	Person Contacted	Status	Date/Time	Called	Copy
Abuse Registry 1-800-962-2873	Name_____ ID# _____	Report Accepted Yes ☐ No☐		☐	☐
Agency for Health Care Administration	Name: _____	N/A		☐	☐
Law Enforcement-Department ☐	Officer's Name_____ Badge #_____ Case # (if avail)_____	N/A		☐	☐
Parent/Guardian/ Family Member Name	Name: _____	N/A		☐	☐
Other (Please Specify) _____	Name: _____	N/A		☐	☐
Other (Please Specify) _____	Name: _____	N/A		☐	☐
DCF (for providers only)	**Name:** _____	N/A		☐	☐

VII. REVIEW AND SIGNATURES

	NAME	SIGNATURE	TITLE	PHONE #	DATE
REPORTING EMPLOYEE					__/__/__
SUPERVISOR					__/__/__

DCF INTERNAL NOTIFICATION

Individual/Agency Notified	Date/Time	Called	Copy	Individual/Agency Notified	Date/Time	Called	Copy
Client Relations		☐	☐	Employee Safety Program		☐	☐
District Administrator		☐	☐	Florida Local Advocacy Committee		☐	☐
Division Director/ Facility Director		☐	☐	H.R. Workers' Compensation Coordinator (employee related incidents only)		☐	☐
District Legal Counsel		☐	☐	Program Office/Risk Manager		☐	☐
DS Support Coordinator/Case Manager		☐	☐	Others – (Please specify) _____		☐	☐
EEOC		☐	☐	Contract Manager		☐	☐
Public Information Officer		☐	☐	Missing Children's Unit		☐	☐

VIII. DCF REVIEW AND SIGNATURES

	NAME	SIGNATURE	TITLE	PHONE #	DATE
Incident Report Liaison					__/__/__
Senior Supervisor					__/__/__

INCIDENT DEFINITIONS

The definitions apply to DCF direct or contractual services/employees

1. Abuse/Neglect/Exploitation. A reportable event where a client/employee is the subject of abuse, neglect, or exploitation.

2. Aggression/Threat . The client engages in verbal threats to harm or aggression towards another person.

3. Altercation. A physical confrontation occurring between a client and employee or two more clients at the time services are being rendered, or when a client is in the physical custody of the department, which results in one or more clients or employees receiving medical treatment by a licensed health care professional.

4. Baker Act. Client is placed into a facility under the Baker Act.

5. Bomb Threat. Any threat of harm to property or persons involving an explosive device that is received verbally, in writing, electronically or otherwise.

6. Client Injury/Illness. A medical condition of a client requiring medical treatment by a licensed health care professional sustained or allegedly sustained due to an accident, act of abuse, neglect or other incident occurring while in the presence of an employee, in a Department of Children and Families or contracted facility or service center or who is in the physical custody of the department.

7. Client Death. Any person whose life terminates due to or alleged due to an accident, act of abuse, neglect or other incident occurring while in the presence of an employee, in a Department of Children and Families operated or contracted facility or service center, while in the physical custody of the department; or when a death review is required pursuant to CFOP 175-17,Child Death Review Procedures.

8. Contraband/Drugs (or non-authorized material) Discovery of contraband. Employee/client found with contraband which includes intoxicating beverage, controlled substance, weapon or device designed to be used as a weapon or explosive substance, and/or, anything specifically prohibited in writing by the Department (Ref. CFOP 70-12).

9. Misconduct/Criminal Activity. Action resulting in potential liability. Conduct resulting in a law violation. Falsification of State or client records by an employee.

10. Contraband/Drugs (or non-authorized material) Discovery of contraband. Employee/client found with contraband which includes intoxicating beverage, controlled substance, weapon or device designed to be used as a weapon or explosive substance, and/or, anything specifically prohibited in writing by the Department (Ref. CFOP 70-12).

11. Theft/Vandalism/Damage/Sabotage. Loss of state or private property of significant value or importance.

12. Elopement/Runaway. *The unauthorized absence beyond eight hours, or other time frames as defined by a* specific program operating procedure or manual, of a child or adult who is in the physical custody of the department.

13. Emergency Room Visit. The client is taken to an emergency medical facility for assessment and/or treatment.

14. Escape. The unauthorized absence as defined by statute, departmental operating procedure or manual of a client committed to, or securely detained in a Department of Children and Families mental health or developmental services forensic facility covered by Chapters 393, 394 or 916, FS.

15. Hospital Admission. The client is admitted to the hospital for surgery or scheduled medical procedures.

16. Client Injury/Illness. A medical condition of a client requiring medical treatment by a licensed health care professional sustained or allegedly sustained due to an accident, act of abuse, neglect or other incident occurring while in the presence of an employee, in a Department of Children and Families or contracted facility or service center or who is in the physical custody of the department.

17. Media Coverage Media coverage that may have an adverse impact of the Department's ability to protect and serve its clients.

18. Medications Issue. The client is prescribed psychotropic medication requiring consent of parent and/or court order and issue not resolved. Issue of incorrect medication or wrong dosage of correct medication. Dosage of prescribed medication is omitted, or the client has an adverse reaction to medication. This would not include suicide attempts by intentional overdose, which are Suicidal Attempts.

19. Misconduct/Criminal Activity. Action resulting in potential liability. Conduct resulting in a law violation. Falsification of State or client records by an employee.

20. Physical Aggression. The client engages in physical aggressive behavior that is threatening towards persons or destructive to property or animals, e.g. overturning furniture, throwing objects, striking walls, etc.

21. Self-Injurious Behavior. The client inflicted upon him/herself or subject self to potential danger (cutting oneself, walking into traffic).

22. Theft/Vandalism/Damage/Sabotage. Loss of state or private property of significant value or importance

23. Sexual Battery. An allegation of sexual battery by a client on a client, employee on a client, or client on an employee as evidenced by medical evidence or law enforcement involvement.

24. Suicide Attempt. An act which clearly reflects the physical attempt by a client to cause his or her own death while in the physical custody of the department or a departmental contracted or certified provider, which results in bodily injury requiring medical treatment by a licensed health care professional.

25. Suicidal Ideation/Threat. The client talks about killing him/herself or verbally suggests the possibility of killing him/herself.

26. Theft/Vandalism/Damage/Sabotage. Loss of state or private property of significant value or importance.

27. Theft/Vandalism/Damage/Sabotage. Loss of state or private property of significant value or importance.

28. Other Incidents. An unusual occurrence or circumstance initiated by something other than natural causes or out of the ordinary such as a tornado, kidnapping, riot or hostage situation, which jeopardizes the health, safety and welfare of clients who are in the physical custody of the department.

F/groups/resplan/incidents/form7101 Rev. 2/25/02

EXHIBIT F

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

SECURITY AGREEMENT FORM

The Department of Children and Families has authorized you:

_____

Employee's Name / Organization

to have access to sensitive data through the use of computer-related media (e.g., printed reports, microfiche, system inquiry, on-line update, or any magnetic media).

Computer crimes are a violation of the department's disciplinary standards and, in addition to departmental discipline, the commission of computer crimes may result in Federal and/or State felony criminal charges.

- By my signature, I acknowledge that I have received, read and understand the Computer Related Crimes Act, Chapter 815, F.S.
- By my signature, I acknowledge that I have received, read and understand Sections 7213, 7213A, and 7431 of the Internal Revenue Code, which provide civil and criminal penalties for unauthorized inspection or disclosure of Federal tax data.
- By my signature, I acknowledge that it is the policy of the Department of Children and Families that under no circumstances shall any contract employee be allowed access to IRS tax information.

I understand that a security violation may result in criminal prosecution according to the provisions of Federal and State statutes and may also result in disciplinary action against me according to the provisions in the Employee Handbook. I agree to be bound by the provisions of CFOP 50-6. The minimum department security requirements are:

- Personal passwords are not to be disclosed.
- Information is not to be obtained for my own or another person's personal use.

Print Employee's Name	Signature of Employee	Date
Print Supervisor's Name	Signature of Supervisor	Date

CF 114, PDF 03/2004

Distribution of Copies: Original – Personnel File/Contract File
Copy – Security File
Copy – Employee Copy

ATTACHMENT II

The administration of resources awarded by the Department of Children & Families to the provider may be subject to audits as described in this attachment.

MONITORING

In addition to reviews of audits conducted in accordance with OMB Circular A-133 and Section 215.97, F.S., as revised, the Department may monitor or conduct oversight reviews to evaluate compliance with contract, management and programmatic requirements. Such monitoring or other oversight procedures may include, but not be limited to, on-site visits by Department staff, limited scope audits as defined by OMB Circular A-133, as revised, or other procedures. By entering into this agreement, the recipient agrees to comply and cooperate with any monitoring procedures deemed appropriate by the Department. In the event the Department determines that a limited scope audit of the recipient is appropriate, the recipient agrees to comply with any additional instructions provided by the Department regarding such audit. The recipient further agrees to comply and cooperate with any inspections, reviews, investigations, or audits deemed necessary by the Chief Financial Officer or Auditor General.

AUDITS

PART I: FEDERAL REQUIREMENTS

This part is applicable if the recipient is a State or local government or a non-profit organization as defined in OMB Circular A-133, as revised.

In the event the recipient expends $300,000 ($500,000 for fiscal years ending after December 31, 2003) or more in Federal awards in its fiscal year, the recipient must have a single or program-specific audit conducted in accordance with the provisions of OMB Circular A-133, as revised. In determining the Federal awards expended in its fiscal year, the recipient shall consider all sources of Federal awards, including Federal resources received from the Department of Children & Families. The determination of amounts of Federal awards expended should be in accordance with guidelines established by OMB Circular A-133, as revised. An audit of the recipient conducted by the Auditor General in accordance with the provisions of OMB Circular A-133, as revised, will meet the requirements of this part. In connection with the above audit requirements, the recipient shall fulfill the requirements relative to auditee responsibilities as provided in Subpart C of OMB Circular A-133, as revised.

The schedule of expenditures should disclose the expenditures by contract number for each contract with the Department in effect during the audit period. The financial statements should disclose whether or not the matching requirement was met for each applicable contract. All questioned costs and liabilities due the Department shall be fully disclosed in the audit report package with reference to the specific contract number.

PART II: STATE REQUIREMENTS

This part is applicable if the recipient is a nonstate entity as defined by Section 215.97(2)(l), Florida Statutes.

In the event the recipient expends a total amount of state financial assistance equal to or in excess of $300,000 in any fiscal year of such recipient, the recipient must have a State single or project-specific audit for such fiscal year in accordance with Section 215.97, Florida Statutes; applicable rules of the Executive Office of the Governor, the Chief Financial Officer and Chapters 10.550 (local governmental entities) or 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General. In determining the state financial assistance expended in its fiscal year, the recipient shall consider all sources of state financial assistance, including state financial assistance received from the Department of Children & Families, other state agencies, and other nonstate entities. State financial assistance does not include Federal direct or pass-through awards and resources received by a nonstate entity for Federal program matching requirements.

In connection with the audit requirements addressed in the preceding paragraph, the recipient shall ensure that the audit complies with the requirements of Section 215.97(7), Florida Statutes. This includes submission of a financial reporting package as defined by Section 215.97(2)(d), Florida Statutes, and Chapters 10.550 or 10.650, Rules of the Auditor General.

The schedule of expenditures should disclose the expenditures by contract number for each contract with the Department in effect during the audit period. The financial statements should disclose whether or not the matching requirement was met for each applicable contract. All questioned costs and liabilities due the Department shall be fully disclosed in the audit report package with reference to the specific contract number.

PART III: REPORT SUBMISSION

Any reports, management letters, or other information required to be submitted to the Department pursuant to this agreement shall be submitted within 180 days after the end of the provider's fiscal year or within 30 days of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes:

A. Contract manager for this contract (2 copies)

B. Department of Children & Families
ASFMI
Building 2, Room 301
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

C. Copies of the reporting packages for audits conducted in accordance with OMB Circular A-133, as revised, and required by Part I of this agreement shall be submitted, when required by Section .320(d), OMB Circular A-133, as revised, by or on behalf of the recipient directly to the Federal Audit Clearinghouse designated in OMB Circular A-133, as revised (the number of copies required by Sections .320(d)(1) and (2), OMB Circular A-133, as revised, should be submitted to the Federal Auditing Clearinghouse), at the following address:

Federal Audit Clearinghouse
Bureau of the Census
1201 East 10th Street
Jeffersonville, IN 47132

and other Federal agencies and pass-through entities in accordance with Sections .320(e) and (f), OMB Circular A-133, as revised.

D. Copies of reporting packages required by Part II of this agreement shall be submitted by or on behalf of the recipient directly to the following address:

Auditor General's Office
Local Government Audits/342
Claude Pepper Building, Room 401
111 West Madison Street
Tallahassee, Florida 32399-1450

Providers, when submitting audit report packages to the Department for audits done in accordance with OMB Circular A-133 or Chapters 10.550 (local governmental entities) or 10.650 (nonprofit or for-profit organizations), Rules of the Auditor General, should include, when available, correspondence from the auditor indicating the date the audit report package was delivered to them. When such correspondence is not available, the date that the audit report package was delivered by the auditor to the provider must be indicated in correspondence submitted to the Department in accordance with Chapter 10.558(3) or Chapter 10.657(2) Rules of the Auditor General.

PART IV: RECORD RETENTION

The recipient shall retain sufficient records demonstrating its compliance with the terms of this agreement for a period of six years from the date the audit report is issued and shall allow the Department or its designee, Chief Financial Officer or Auditor General access to such records upon request. The recipient shall ensure that audit working papers are made available to the Department or its designee, Chief Financial Officer or Auditor General upon request for a period of three years from the date the audit report is issued, unless extended in writing by the Department.